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ELDERLY HEALTH CARE IN MISSISSIPPI

HEARING

BEFORE THE

SUBCOMMITTEE ON AGING

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

SECOND SESSION

ON

EXAMINING THE NEED AND NEW APPROACHES BEING TAKEN TO PROVIDE BETTER HEALTH CARE AND SERVICES FOR THE ELDERLY

OCTOBER 20, 1988
TUPELO, MS

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ELDERLY HEALTH CARE IN MISSISSIPPI

THURSDAY, OCTOBER 20, 1988

U.S. SENATE,
SUBCOMMITTEE ON AGING,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Tupelo, MS.

The subcommittee met pursuant to notice at 10 a.m., in the North Mississippi Medical Center, Tupelo, Mississippi, Senator Thad Cochran presiding.

Present: Senator Cochran.

OPENING STATEMENT OF SENATOR COCHRAN

Senator COCHRAN. This hearing will now come to order. Good morning, everyone. Before we begin, I want to thank the North Mississippi Medical Center for hosting the hearing and for the hospitality and the many courtesies that have been extended in planning and making arrangements for the hearing. This facility is one in which the entire state can take pride and I sincerely appreciate your allowing us to be here today.

I want to welcome each one of you and to especially thank those of you who have traveled some distance to be with us. The hearing will explore elderly health care issues in our state and some of the innovative approaches being taken by the medical community to adapt to the changing needs of our elderly citizens. The statistics show an ever increasing number of older citizens in our population and the added demand this puts on our health care resources.

Witnesses before us today will be providing the information we need for the record in helping us assess both the current status of elderly health care in the state and the outlook for the future. Health officials and professionals throughout our state are working to improve the quality of life for all Mississippians, young and old alike. I'm encouraged by the efforts being made in the face of some big challenges. The willingness to address old problems and new problems, too, with creative solutions.

It is my hope that the Subcommittee can leave here today with a better understanding of our state's particular situation in order to be more effective in shaping federal health policy in the future. We must work together at all levels, federal, state and local.

Hospitals play a key role in providing health care services for our elderly, and we will be giving this sector particular attention today. The environment in which hospitals operate is undergoing fundamental change and restructure due to many forces. These forces include a decline in the use of in-patient hospital services as a result of changes in payment systems, insurance coverage, consumer attitude, medical practice patterns, and new technology. In addition, declining revenues due to inadequate Medicare reimbursements for expensive cases pose real threats for many of our hospitals, as does the increasing incidents of uncompensated care.

These are some of the factors affecting our hospitals in Mississippi, and they are especially significant in smaller towns. We will be looking today at ways in which hospitals are meeting these challenges and ways in which federal health policy can better complement their efforts.

We will also be looking at another fundamental issue affecting access to health care for our elderly, health care personnel. There are unique challenges involved in attracting and retaining physicians and other health care professionals in the small towns and rural communities of our state. Specialization is becoming more and more the fashion in medical practice today leaving us with a shortage of general practitioners. We will be looking at the status of this situation, policies that may escalate the problem and efforts to address it. Certainly, the nursing shortage is compounding this problem and this will be discussed.

Clearly, there are many issues that we will be unable to explore in a one-day hearing. Nursing home care and home health are major concerns to some elderly citizens, and the issue of long-term health care is one which Congress will be debating next year. In addition, mental health care is an important factor in the overall picture of health care and we will have to focus on that subject on another occasion.

Today we will begin our hearing with testimony from Dr. Alton Cobb and Dr. Clinton Smith, who will make up our first panel. Dr. Cobb is our state health officer with the Mississippi State Department of Health in Jackson. And Dr. J. Clinton Smith is director of the Division of Medicaid of the Office of the Governor in Jackson. If you'll both come forward now and take places at the witness table, we will proceed with our hearing.

These witnesses have provided written statements which will be included in full in our hearing record. We would encourage you to make whatever summary comments you would like to make to the hearing, and then we'll have an opportunity to discuss your testimony and ask questions that we might have. Dr. Cobb, you may proceed. Thank you very much for being here.

STATEMENTS OF ALTON COBB, M.D., M.P.H., STATE HEALTH OFFICER, MISSISSIPPI STATE DEPARTMENT OF HEALTH, JACKSON, MS; AND J. CLINTON SMITH, M.D., M.P.H., DIVISION OF MEDICAID, OFFICE OF THE GOVERNOR, JACKSON, MS

Dr. Cobb. Thank you for the opportunity. I think as you have said, Senator Cochran, we have in Mississippi, as in the nation, increasing numbers of the elderly. In our state, the elderly are poorer than in the rest of our nation, and I am sure that many or more of them live in rural areas than in some other sections of our country. The elderly persons, of course, are more prone to chronic disease and the need for long-term care and the necessary continuity for that care due to the type of illnesses that they frequently have.

As we all know, utilization of health care is much greater in the latter years of life particularly among the frail elderly or those that we generally refer to as over 80 to 85 years of age. In my judgment the health care delivery system as we have known it is not able to address in a comprehensive manner the needs of many of our elderly. The need for physician services for the elderly is projected to increase by 30 percent by the year 2000.

We have increased our physician supply considerably in Mississippi in the last few years. We have come more nearly to the ratio of our other states, but we still have a shortage of primary care physicians and particularly in some of the smaller towns and the rural areas. We have a shortage of physicians and we have problems with maldistribution in that we do not have physicians in many, many of our rural areas that are prepared to care for our elderly people. This shortage has been alleviated, as I have mentioned, by our medical school and it's advancing a supply physicians, of new physicians, coming into our state.

I heard Dr. Nelson mention a few nights ago that 70 percent of our graduates continue to practice in our state, which is quite a mark of achievement for a state medical school. The National Health Service Corps has been helpful in supplying physicians to some of the rural areas to care for the elderly, but that program as we know has been drastically altered and future placements are likely to be fewer than in the past.

I want to make a particular comment about a potential I think we have for developing residency training programs in family medicine in community hospitals such as this center right here in Tupelo, MS. I think if these could be developed and these physicians could become acquainted with the opportunities of serving the elderly as well as meeting other primary care needs in our state in the smaller communities that surround this center, I think there's a lot of potential for increasing and maintaining or more than maintaining, of increasing our supply of primary care physicians to serve the elderly in the future.

Another barrier to access to the physician services for the elderly in our state is the relatively low number of our physicians who accept Medicare assignment. I'm sure we'll hear more about that from the physicians who testify later. There are certain constraints that work on that in that many times the fees that are paid under Medicare are not equivalent to the customary fees of the physicians. We have only about 33 percent of our doctors in Mississippi who accept assignment. That does create problems for the elderly in the difficulties that they have in arranging payment themselves or understanding the claims processing. It all gets kind of complicated for our elderly citizens.

I would look forward to the time that we would have a more adequate fee system or payment system that would encourage more physicians to accept assignment. I think that perhaps the resource based relative value base system that is now being proposed out of Harvard might have some potential, as it will provide more incentives, as I understand it, oriented towards primary care than we've had in the past.

Another issue I'd like to bring up, highly restrictive interpretations of home health care reimbursement rules. This has tended to reduce the access of many elderly persons to home health services. Under the prospective payment system for hospitals, about which I'm sure you will hear many comments from the hospital representatives, patients have been leaving hospitals sooner and generally sicker.

The Medicare rules for swing bed participation are highly restrictive and only selected patients are eligible. Therefore, many frail elderly persons are being referred to Home Health agencies for service. Stringent criteria for home health services as prescribed by HCFA have caused many elderly to be declared ineligible for Medicare reimbursement for this needed home care.

In my judgment, we are simply squeezing the total Medicare system too severely for budget reductions to allow for a reasonable access to necessary care for the aged. Let me mention the fact that as far as access to home health, all county health departments in our state are providers of home health plans, many of our hospitals, and we have a number of fine private agencies that are providing home health services in our state. We generally have this service available statewide.

The problem is access to the service for all who would benefit. This is limited mainly by level of care for Medicare payment but for some persons by eligibility, as well. We are addressing some of this problem to some extent through the provision of home nursing care funded by some federal grants administered by the state's Council on Aging. With these funds we're able to employ nurses and aides and other care-givers in some of our rural counties to fill the gap and to pick up those who might, say, fall through the cracks of the eligibility requirements for level of care under Medicare for Home Health.

In addition, we recently applied for and were successful in receiving a grant of $780,000 from the Health Resources and Services Administration to provide home health care to low income persons who have no payment source for this care. This project will provide funding for nurses, aides and social workers in over twenty of our counties to work with families and their physicians to provide services to the elderly and others who do not meet the level of care guidelines for home health.

We hope with this to build some systems, working with physicians, working with hospitals and with the core of it being the support from this project to demonstrate that we know there's a need to demonstrate that this is an effective, cost effective, as well as a humane way of meeting the needs for in-home services. The availability of these home health care services and related services undoubtedly can prevent needless institutionalization for many people, and we urge your support of the expansion of such programs, which have the flexibility to deal with the patients needs more at the community level rather than a prescribed, very stringent set of guidelines as to who qualifies for the level of care under Medicare.

I think this back-up to home health service would be very effective in our state to help pick up those needs and problems that the home health program as it's traditionally operated does not meet.

Let me mention another issue. That is the care-givers for those at home. There is a need for support groups. It's a tiring and a strenuous and a stressful experience to care for an elderly person at home. They prefer to be at home, but if we can encourage more in the way of voluntary support groups to really provide that kind of personal and social support services, it could be very helpful. Some have mentioned the idea that for those who care for the elderly at home that perhaps tax credit breaks or some other type of system that would encourage our caring for people long term at home versus rushing to institutionalize them too soon.

We do have as a result, I think, of not having these alternatives some inappropriate placement. We have people placed in nursing homes who really would more appropriately be cared for at home or in other settings. We have, of course, many of our elderly have serious problems in financing long-term care. That's a national issue. I do believe the recent expansion of Medicare coverage up to, I think it's a hundred and fifty or sixty potential days per year for nursing home care under Medicare will help greatly. I think that's a real step forward. That was done as part of the catastrophic health care bill and the Congress is to be commended for that.

Access to basic preventive health services for the elderly in Mississippi is, in my opinion, fairly good. All our health departments provide influenza and pneumococcal vaccines. There are many sources for blood pressure screening and other preventive services, such as community health centers and hospitals. The access to acute hospital care for the elderly is being threatened in many rural areas, as you alluded to, by the economic difficulties being faced by hospitals. I'm sure the hospital spokespersons will address that quite at length. If we do seek continuation of closing of some of our rural hospitals, we really need to plan for some substitution or some other type of care system.

Clinics, emergency care and transportation will be necessary in order to assure that our persons who need services may be able to avail themselves of those services in the larger communities. Some of our larger hospitals, and I'm sure that they will comment more on this, are establishing affiliations with smaller hospitals. I think there's a lot of potential to encourage that, and I just saw this morning some of the potential with the food service operation at this hospital and the laundry operation. There's a lot of potential there for smaller hospitals and nursing homes in the surrounding area to contract and be supported and backed up by a larger medical center.

I think the residency training programs that I mentioned could fit right in with that to train family physicians in a center like this who would become acquainted with service in the surrounding area and help to build a better assurance that we will have physicians serving our patients in the future.

In summary then, let me emphasize that we must all work together at the federal, state and local levels to establish these comprehensive systems of care for the elderly, whereby the full range of services—ambulatory, emergency, acute hospital care, home health, pharmacy, and long-term care will be available and accessible.

We should always stress, of course, preventive care and home care. And I think more emphasis should be placed on other alternatives of congregate living for the elderly versus simply having nursing homes as about the only choice. There are a lot of other options that our elderly people could have, such as special apartments or living arrangements that would help greatly, I believe, in many instances when it's not possible for them to continue at home with home health and other support services.

It's going to take a lot of work by all of us. It's a big issue. It's probably the major social and medical issue, in my judgment, that's facing us over the next ten to twenty years. It's a pleasure for me to be here, and if there should be an opportunity for questions and discussions, I'll be happy to respond.

[The prepared statement of Dr. Cobb follows:]

HEALTH NEEDS OF THE ELDERLY IN MISSISSIPPI

Presented by
Alton B. Cobb, M.D., M.P.H.
State Health Officer

to the
U. S. Senate Subcommittee on Aging's Hearing
"Elderly Health Care in Mississippi"

October 20, 1988

HEALTH NEEDS OF THE ELDERLY IN MISSISSIPPI

Thank you for providing me with the opportunity to talk with you today about the health care needs of Mississippi's elderly. I will touch briefly on some of the health status and health system problems facing the elderly and then address recommendations for solutions to some of these problems.

As you are aware, the elderly in the nation and in Mississippi are living longer. In 1900, only 3 percent of Mississippians were over 65. In 1986, that proportion had risen to 11 percent. Most of the elderly live and function independently; however, approximately 17 percent of the elderly are unable to perform essential activities of daily living and must have ongoing help from family or other sources.

The elderly are more prone to acute episodic illness and long term chronic conditions which require various levels of long term care. Consequently, the elderly consume a disproportionate share of health services. Health care utilization is greatest in the last years of life and among the oldest of the old. Unfortunately, the health care delivery system is not always able to address in a comprehensive manner the needs of this population.

The need for physician services for the elderly is projected to increase by 30 percent by the year 2000. Although it appears that the overall supply of physicians will be adequate to meet the needs of the state's elderly, the geographic maldistribution of these physicians means that many of the rural elderly will still not have access to needed primary physician care. The shortage of primary care physicians has been alleviated in part in the past by the placement of National Health Service Corps physicians, but that program has been drastically altered, and future placements are likely to be fewer than in the past. Residence training programs for family physicians in our larger hospitals would be very helpful in increasing our supply of family physicians.

Another barrier to access to physician services for the elderly is the low number of physicians in the state who will accept Medicare assignment. The payments for physician services under Medicare are so low when combined with the disallowance for many services that only 33 percent of doctors in Mississippi accept assignment. While I understand that we must maintain controls on health care expenditures, I feel that if the reimbursement levels under the program were more reasonable, physicians would accept Medicare payments. The relative value based system being proposed would probably help in providing incentives for primary care for the elderly.

In a similar manner, highly restrictive interpretations of Home Health care reimbursement rules have reduced access to this needed service for many elderly patients. Under the prospective payment system for hospitals, about which I am sure you will hear many comments from the hospital representatives, patients have been leaving hospitals sooner and sicker. Medicare rules for swing bed participation are highly exclusive and only selected patients are eligible. Therefore, frail elderly persons are being referred to home health agencies for service. Stringent criteria for Home Health services have caused many elderly to be declared ineligible for Medicare reimbursement for the needed home care. We are simply squeezing the total system too severely to allow for reasonable access to necessary care for the aged.

All county health departments in Mississippi provide home health services; in addition, a number of hospitals and private agencies provide home health services. In my opinion, we generally have this service available statewide. Access to the service for all elderly who would benefit, however, is limited by eligibility for Medicare/Medicaid and the level of care requirements for home health care under these programs.

Mississippi is addressing this problem to a limited extent through the provision of home nursing care funded by federal grants administered by the state's Council on Aging. These funds pay for chronic illness nurses in several counties in the state who provide home health care to elderly persons who have no third party source of payment for such care.

In addition, Mississippi recently applied for and received a grant for $780,000 from the Health Resources and Services Administration to provide home health care to low income persons who have no payment source for this care. We preferred to apply for more funds, but we were unable to meet the matching requirements, which increase each year of the grant.

The availability of home health care services undoubtedly prevent needless institutionalization, and we urge your support of expansion of such programs for which the need is so great. Home care is more economical and personally preferable to the elderly. The State Department of Health has also submitted a request to the state legislature for additional funds for chronic illness care in our Fiscal Year 1990 Budget Request.

We have a shortage of nursing home beds in our state due, in the main, to a state imposed moratorium on new nursing home construction. Many states are using this approach to constrain their state Medicaid budget. We need additional beds and other alternatives such as housing arrangements for the elderly that make the transition to a nursing home easier when needed. Of course, many of our elderly have serious problems in financing long term care. The recent expansion of Medicare coverage for nursing home care will help greatly.

Access to basic preventive health services for the elderly in Mississippi is, in my opinion, good. All our health departments provide influenza and pneumococcal vaccines, and there are many sources for blood pressure screening and other preventive services.

Access to acute hospital care for the elderly is being threatened in many rural areas of the state by the economic difficulties being faced by the rural hospitals. The rural hospital generally serves a limited population, but one which, because of certain differences in the rural and urban populations, is more likely to be in greater need of care. Rural populations generally contain a higher percentage of elderly (65 and older) and low income persons, as well as a population which is less mobile and less able to seek health care outside the community.

While the financial vulnerability of rural hospitals may be affected by numerous factors, there are three interrelated factors that are the most predominant causes of financial threat to our rural hospitals: (1)declining occupancy, (2)the DRG prospective payment system, and (3)uncompensated or indigent care. The community hospital is important to the economic viability of the community as well as a provider of health services. If that system is to disappear from our sparsely populated rural communities, some other system of clinical care, emergency care, and transportation to more definitive care must be established if the health needs of the population, particularly the low income elderly population, are to be met.

In summary, let me emphasize that we must all work together, at federal, state, and local levels, to establish a comprehensive system of care for the elderly, whereby the full range of services (ambulatory, emergency, acute hospital care, home health, pharmacy, and long term care) are available and accessible. We should stress preventive care, home care, and congregate living arrangements for our elderly which would delay or avoid institutionalization and promote a high quality of life so that our older citizens can more fully enjoy the extra years which have been afforded them.

Senator COCHRAN. Thank you very much, Dr. Cobb, for your excellent statement. I appreciate your contribution to the hearing. We will now hear from Dr. J. Clinton Smith. He's a medical doctor and director of the Division of Medicaid in the Office of the Governor of Mississippi. Welcome to the hearing. You may proceed with your statement.

Dr. SMITH. Thank you, Senator Cochran. Again, it's awfully good to see you again and I am absolutely delighted at your interest in the long-term care issues.

I don't need to tell you that as director of the division of Medicaid, this is one of our greatest concerns. In our state, just as in most other states, we use about 40 percent of our total budget to serve 4 percent of the entire population that we serve. That seems to be inequitable on the surface, but when you realize that the average length of stay in the nursing home patient far exceeds that of any other patient that we serve, I think you can see where a relatively larger share of Medicaid dollars do go for the care of the elderly and the blind and the disabled.

Seventy percent of all our budget goes for the aged, blind and disabled. You may know this, but let me remind you that it was in this last legislative session that the legislature reflected its concern about the aged, blind and disabled in passing House Bill 266, which would cover all services including crossover services; that is, buying premiums, deductibles and co-pays as well as giving Medicaid cards for the aged, blind and disabled who are in families up to one hundred percent of the federal poverty level.

This legislation was not funded and must be reconsidered in the 1989 session. But I think the bill does again reflect a growing concern of our own legislature about those people out there who are going into nursing homes who could perhaps instead purchase preventive care on the outside and then forestall the date of that when they would have to utilize more expensive nursing home care.

I became so concerned about the long-term care issues shortly after assuming this office that we created a Division of Long-term Care within our Medicaid agency and the director of that division, Mr. Lew Smith, is with me here today to help respond to any questions that may arise.

I had been asked to focus today on what we popularly refer to as our home and community base services waiver. This is what's known as a model 2176 waiver, which was established to provide certain extended additional services, that is, over and above the services that are usually offered to Medicaid patients. We identify a particular group and after approval by the Health Care Financing Administration, we enhance certain services to that group. In this particular waiver, aged and disabled persons who would otherwise qualify for skilled or intermediate care in our state, upon receipt of an application, are referred to the Area Aging Agency and screened and if they do qualify as persons who would receive intermediate or skilled care, then they're given a choice. They're told, "You can either go into a nursing home or you can receive care in our home and community-based services."

This waiver, unfortunately, is only available in four counties in the state and has just been extended to two additional in the past summer to bring the total to four. Those counties are Forrest and Washington and LeFlore and Lee. There are approximately a hundred and twenty-five persons at each of those sites and so that by the end of this year, there should be approximately five hundred persons statewide who will be recipients of these services.

Now, there are five extra services that are allowed under this waiver. The first is case management; the second is adult day care; the third is respite care; the fourth is homemaker services, and the fifth is expanded home health services.

Let me just delve into case management because I think that this is a new buzz word. It's a new term. It's a new concept that's come about on the health care scene in the past few years. We think of a case manager as a broker of services. This person or this agency coordinates the care that is prescribed by multiple providers of care. He or she provides for continuity of care. For example, if there are physician appointments that need to be made, if there are follow-up appointments, if they're to follow through on visits, if there are arrangements that need to be made for Meals on Wheels and so forth, this is the person who helps coordinate all that care.

Secondly, adult day care. Under terms of our waiver, we allow for at least four hours of adult day care per day and there can be more. And these services are provided on at least one day out of the week and there can be more than that. Incidentally, the flat rate for adult day care under this waiver is twenty dollars per day.

We also provide for respite care, some way to give those people who stay in the home and take care of disabled or elderly persons day after day after day to give them a break. Our waiver provides for thirty days per year of care and no more than fourteen days in sequence at any one time. Respite care is provided for in nursing homes. It's provided for in swing beds and hospitals, and the rate that Medicaid pays for this is the going rate for that institution, the going per diem rate for that particular institution.

Home health services are the fourth expanded service offered in the state. Under our Medicaid program, home health is an optional service. We do cover home health services, but we only cover home health services for Medicaid recipients for fifty days out of the year. Under terms of our waiver, the additional 315 days of the year maximally would be covered. Services offered under home health include skilled nursing care; home health aide visit; physical therapy visits (very important); speech therapy visits (for example, persons who experience strokes); and what is referred to as durable medical equipment, those assistant devices that might aid a person as far as mobility or life support systems are concerned.

And fifth and finally, we do offer homemaker services under terms of the waiver. That involves light housekeeping, food purchasing, help as far as a budget is concerned, and so forth. Our waiver has been set up with two models, Forrest and Lee Counties have—I'm sorry, Forrest and Washington County have one model, and Lee and LeFlore have the other.

The first of these models would pay a flat rate to a case manager of fifty-five dollars a day. That case manager, in turn, would solicit those services throughout the state from whatever health category, and those persons, those services, would bill Medicaid directly. So that's one scenario. That's fifty-five dollars per patient per month.

Now, the second scenario and the one that's operative in Lee and LeFlore Counties is what we call total care management. We pay a rate of three hundred and fifty-four dollars per patient per month, and under terms of that agreement, the Council on Aging, who is the intermediary, the agent for these services, then provides those enhanced services that I referred to, the case management, home health and so forth, and pays providers directly for whom it contracts.

Summing up, the bottom line in all this is that this program will allow, it does allow, it has allowed those persons who want to stay at home to do so and in that sense, it helps keep families intact.

I think there are a couple of caveats that need to be kept in mind. Number one, is the program cost effective? We are presently still collecting information to test whether these services provided at home are either less or more expensive than a person going into a nursing home. I think number two, we've got to keep in mind also that there are many people who want to go into nursing homes because of the socialization aspect. There are persons who feel lonely and isolated and they enjoy being together.

And thirdly, I think any time that we think in terms of going statewide with a waiver such as this, we must be careful to keep in mind what I call the "woodwork" effect; that is, how many people are presently just on the margin of needing these services who if, when these services are made available, then would rush in and take advantage of them, thereby increasing—or I should say exceeding—the number that we think might truly need those services.

So, as I say, this is a pilot program. We're in the early stages of it. We feel very confident, though, that it will prove to be cost effective. It's humane, and within the next two or three years, I feel confident that we will be able to go statewide with it. I have kept my remarks very focused. I'll be glad to expand on them as you wish and to address any other areas in Medicaid that you'd like. Thank you.

[The prepared statement of Dr. Smith follows:]

DIVISION OF MEDICAID

October 13,1988
(Date)

MEMORANDUM

To: Thad Cochran, United States Senator

From: J. Clinton Smith, M.D., MPH

Subject: Director, Division of Medicaid, Office of Governor

Attached is my presentation content at public hearing in Tupelo, Mississippi, October 20,1988.

The number and proportion of persons 60 years old and older in the United States is growing rapidly, including a phenomenal increase in the very old; those individuals 75 years and over - a subsegment of the population especially at risk for long-term care. Mississippi is no exception to these population trends. In 1986, 418,000 individuals, or 15% of the State's population, was represented by the 60 years plus category which equates to one (1) in every six (6) Mississippians. There was approximately 138,000 people 75 years or older in 1986.

Since July 1, 1981, in Mississippi, there has been a general moratorium on the construction of new nursing homes with only a few specific exceptions, and then, only through enactment by legislative authority. On one hand we are experiencing the rapid acceleration of the elderly population. On the other hand, long term health care is hindered due to limitation of beds plus growing health care costs. Certainly we have both the responsibility and desire to attend to the health care needs of our elderly, but with these given restrictions - how do we do it? According to Webster's 9th New Collegiate Dictionary the definition of waive is to "Give up, Forsake". Waiver is defined as "the act of intentionally relinquishing or abandoning a known right, claim, or privilege. Section 1915(c) of the Social Security Act provided the Secretary of Health and Human Resources with the authority to waive certain Medicaid statutory requirements enabling states to offer a wide array of home and community based services as an alternative to institutionalization. This provision was added to the statute as part of Public Law 97-35, the Omnibus Budget Reconciliation Act of 1981. Prior to this

Legislation the Medicaid program provided little coverage for long-term care services in a noninstitutional setting, but offered full or partial coverage for such care in an institution. In addressing these concerns, Section 2176 of Public Law 97-35 was enacted, adding Section 1915(c) to the Social Security Act and thus establishing the Medicaid waivers. A home and community-based waiver offers the State broad discretion not generally afforded under the State Plan so that the State can address the needs of individuals who would otherwise receive costly nursing home care provided under the State Medicaid Plan.

Forty-nine (49) states have submitted requests to the Health Care Financing Administration for some type of home and community-based services program. Of the 49 requests, forty-six (46) have been approved and three (3) are still pending approval. When submitting a waiver request, the State must provide assurances that the average per capita Medicaid cost will not exceed the cost per capita that would have been incurred without the waiver. States must specify in the waiver request the projected number of people to be served. Those Medicaid recipients participating in the waivered services are limited to one of the following target groups or any subgroup thereof: 1) Aged or disabled, or both; 2) Mentally retarded or developmentally disabled, or both; 3) Mentally ill.

Request for a home and community-based services waiver must also include:

1) Type of waiver desired - For example, Mississippi's waiver is limited to those individuals who fit into the aged and/or disable category.

2) The group that will be served. The State cannot develop a new eligibility group. As previously mentioned, participants must fall into one of the three existing Medicaid eligibility categories.
3) A statement that services are necessary and needed to avoid institutionalization.
4) A list of all available providers with their qualifications.
5) The State must describe a level of care determination. In Mississippi the same criteria utilized for nursing home level of care determination is used in the Home and Community-Based Services Program.
6) Definition of the services to be provided. In Mississippi, we provide five major services with the waivered program;
    a) Case Management
    b) Home Health
    c) Adult Day Care
    d) Institutional Respite Care
    e) Homemaker Services

I'll define these services in greater detail shortly.

In November, 1986, the Division of Medicaid began a pilot project for Home and Community-Based Services in Forrest and LeFlore Counties. The pilot project is an effort to reduce nursing home placement by providing more services within the patient's home. The project must also demonstrate the cost effectiveness of delivery of services in the home versus nursing home cost. In July, 1988, HCFA approved Mississippi's amendment to the original waiver to allow two new counties, Lee and Washington, to be added to the demonstration project. This increased the number to be served from 300 to 500 recipients. Now you might be wondering what would constitute an amendment? An amendment must be submitted to HCFA for approval whenever there is:

1) Change in population group
2) Change in total cost
3) Change in definition
4) Change in provider
5) Change in service area
6) An addition or deletion of a service

In order to obtain knowledge, experience, and data on the most efficient and cost effective method of implementing the Home and Community-Based Services, the Division of Medicaid established two different methods for providing and reimbursing the services. In the Forrest and Washington Counties Project area, the Council on Aging contracts with a private provider for Case Management Services and the Council on Aging is paid a monthly fee of $55.00 for each client in the program to cover the cost. The case manager refers the patient for all other needed services; existing Medicaid services as well as the additional Home and Community-Based Services, and each provider bills directly to the Medicaid fiscal agent for reimbursement.

In the Lee and LeFlore Counties Project area, the Council on Aging contracts with the Medicaid Division to provide case management and all other additional Home and Community -Based Services for a capitation fee of $354 a month for each patient in the program. The Council on Aging provides the case management through a member of the staff at the Area Agency on Aging and contracts with provider of services for the additional Home and Community - Based Services and reimburses the provider for the service.

As I previously mentioned there are five services to which Home and Community-Based recipients are entitled:

1) Case Management
2) Home Health (in excess of the 50-visit maximum)
3) Homemaker Services
4) Adult Day Care
5) Respite Care

1) Case Management: The Case Managers in Forrest, Lee, Washington and LeFlore Counties screens active SSI-Medicaid recipients (aged, blind or disabled) for enrollment in the Home and Community-Based Program. Patients enrolled must meet the medical criteria for skilled or intermediate nursing home placement. The Case Manager determines the above services needed to maintain the patient at home and refers the individuals to providers of these services. The Case Management Team, consisting of a Registered Nurse and a Social Worker, will assure continuity of care, coordination of the total services care plan, and monitoring of the service delivery so the health and safety of the recipient is protected.

In Forrest and Washington Counties, Mississippi Council on Aging bills $55.00 per client per month directly to the Division of Medicaid. This claim will always pay $55.00 regardless if the claim reflects one (1) day or thirty-one (31) days or one (1) unit or one hundred (100) unis.

In LeFlore and Lee Counties, the Division of Medicaid pays directly to Mississippi Council on Aging the total sum of $354.00 per client per month. The Mississippi Council on Aging then channels the $354.00 to the Area Agency on Aging. The claim will always pay $354.00 regardless if it reflects one (1) day or thirty-one (31) days or one (1) unit or one hundred (100) units. This $354.00 is a total capitated fee.

2) Home Health: To be eligible for Home Health, the recipient must be essentially homebound. The first fifty (50) Home Health visits are covered under the regular Division of Medicaid's Home Health Program. Any visit after the first fifty (50) visits is contracted by Mississippi Council on Aging to AAA in LeFlore and Lee Counties.

In Forrest and Washington Counties the provider bills directly to Medicaid after the first fifty (50) visits; and in LeFlore and Lee Counties it is included in the $354.00 monthly capitation fee after the first fifty (50) visits.

Services offered under the Division of Medicaid's Home Health Program:

(a) Skilled Nursing Visit
(b) Physical Therapy Visit
(c) Speech Therapy Visit
(d) Home Health Aidè Visit
(e) Durable Medical Equipment

3) Homemaker Services: Homemaker Services is the provision of surrogate care in the absense of the caretaker. This service includes attendant care, as well as instruction on more effective methods of home management, self-care and social skills. These services are provided by a trained, supervised homemaker where the individual regularly responsible for these activities is temporarily absent or unable to manage and care for the home. Homemaker Services bills $7.20 per hour.

In Forrest and Washington Counties, the provider bills directly to Medicaid. In LeFlore and Lee Counties, it is included in the $354.00 monthly capitation fee.

4) Adult Day Care: Adult Day Care providers may be hospital or nursing home based or freestanding centers. The care should be furnished for four (4) or more hours per day on a regularly scheduled basis, and shall be provided for one (1) or more days per week. Adult Day Care bills $20.00 per day for reimbursement. In Forrest and Washington Counties the provider bills directly to Medicaid; and in LeFlore and Lee Counties it is included in the $354.0 monthly capitation fee.

5) Respite Care: Respite Care is furnished to an individual who is unable to care for himself/herself and is provided on a short-term basis because of the absense or need for relief of those persons normally providing care. Respite care is limited to thirty (30) days per fiscal year, not to exceed fourteen (14) days at a time. In Forrest and Washington Counties, the nursing home/swing bed, where Respite Care will be provided, is paid at the regular per diem rate for the facility. In LeFlore and Lee Counties, the cost for this service is included in the capitation fee of $354.00 per month.

Presently, 321 Medicaid recipients have taken advantage of this new, exciting project in our State. If you know of someone who would benefit from the program, please inform them about it. Here, in the Lee County Area, services and participants are coordinated through the Three Rivers Planning and Development District. Their address is: P.O. Drawer "B", Pontotoc, MS, 38863. The phone number is 489-2415. The Case Manager is Buster Turner.

Also, anyone can refer a potential client for services. Referrals in the past have come from physicians, hospital social workers, home health agencies, nursing home waiting lists, and clients, just to name a few.

The Division of Medicaid plans to expand the Home and Community-Based Services statewide. In order to accomplish this, State Legislative authorization will have to be obtained as well as approval from HCFA to allow this major expansion. We believe that Home and Community-Based Services is a very real alternative to nursing home placement and is of paramount worth to those it is intended to serve.

Senator COCHRAN. Thank you very much, Dr. Smith, for your testimony.

I recall in the presentation of Dr. Cobb relating to the need for more family medicine practitioners, that in our hospitals, programs for residents training in facilities such as this one would be an improvement, something we need to work on. I understand that public health service act does provide grants and contracts to hospitals and schools of medicine to develop and operate training programs in family medicine for those who plan to practice or teach family medicine. Are we able to utilize, or have we in Mississippi utilized these grants or training programs to help us in this regard?

Dr. COBB. One of the spokespersons here from the Medical Center could probably more specifically say what grants have been available. We do have a very fine family medicine training program, family practice training program, at the University Medical Center in Jackson. And I've forgotten the number of resident slots, but it's several each year.

My remarks were not intended in any way to infer any criticism of that program. I think that the weakness I would speak to statewide is that the residents do not get experience and do not work out in community hospitals such as this one. I think there would be a lot of merit in developing such as Georgia has, Alabama, Tennessee, a number of our surrounding states, family medicine training programs that utilize community hospitals out in the state for such training. I think that the physician there is trained more in the setting in which he's more likely to practice, rather than a university medical center and maybe Jackson hospitals. They're a little different sometimes.

And then, too, there's opportunity for those residents during their training, if they were training here, to have some practice experience in some of the smaller hospitals and surrounding areas, probably get acquainted with people in those communities. They're more likely to settle in those communities and practice there. It tends to disperse them. It tends to encourage them to eventually practicing out in the state where they are more needed, rather than tending to concentrate in Jackson and the surrounding area. There's some research that supports that, that residents, physicians tend to settle more likely nearer where they have trained.

So that would be my only criticism, if that's the word for it, or fault for the present system we have. It's not that we don't have a good family medicine training program. It's that we're not going out in the state as our neighboring states are doing, and I think that would be something we could work together on to see if we could find sources for support. I believe in those other states in the South that the state itself helps to support those programs, as well as using the funds that you referred to that are available from the federal level.

Senator COCHRAN. Well, that's an interesting observation. Is this something that can be pushed along by a change in federal policy, or is this more or less left up to individual training initiatives in the medical centers and community hospitals themselves?

Dr. COBB. Perhaps Mr. Hicks or someone who's explored this, say, from this hospital viewpoint could comment. I think most of those programs do have medical school affiliation. It's probably necessary in order to have an accredited program, but they don't necessarily need to be fully managed by and sponsored by the Medical Center. They might have affiliation—say if there were a program here they might have an affiliation with the medical school in Tennessee as well as the medical school in Jackson. But it does take money and it takes support, and it's probably more than a hospital itself could be expected to fund and to operate.

Senator COCHRAN. This was a question that I was going to ask to the next panel of witnesses who will focus on hospitals and what they're doing, the problems they face, but it's whether or not there is anything, from your standpoint, that the federal policy-makers could do to help ensure a greater number of health care professionals in the smaller towns and rural communities. Do you have any special idea of your own?

I know you've had to have thought about this and seen the problems that we have in Mississippi of physicians leaving the smaller towns, nurses who tend to want to live in the larger towns of a state and the smaller towns and rural communities are just having a more difficult time as we go along attracting people into their community.

Dr. COBB. Well, one thing is the type of program that we've just discussed. Some states are exploring ideas like particular tax incentives or advantages to encourage physicians to practice in smaller communities. I believe there are several states that are working on that. I think that's been proposed at the federal level as well. I know all that gets pretty complicated when you get into tax systems and tax breaks and that sort of thing, but I think basically what we need to do is to try to train people nearer to where they're needed and let them have experiences in providing services in those environments and they're much more likely then to practice there.

I think additional federal support targeted towards family medicine training, towards nurse practitioner training or nurse training that would encourage more of an out-state look rather than so much of big city—environment. What we need is more decentralized programs. I know some states have area health education centers they have had under which they have had educational programs. We have not had that. I really don't know why. But anyway, any federal efforts and combined with state efforts that could encourage that would help a lot in the supply situation in the future. And that's really very critical that we plan for that and try to address that.

Senator COCHRAN. One other criticism that I've heard is that the federal policies tend to reimburse those who work in the larger cities a lot more and they do at a higher level than in the smaller towns and rural communities and that you're going to encourage physicians and other health care professionals and hospitals to locate and expand in those areas where they will be rewarded more.

Dr. COBB. I had that in my notes, my statement, and I'm sure Dr. Hill and others will tell you about it. But I think that is a problem. I think the differential payment system of both hospitals and physicians that tend to make it less attractive to provide and to locate and to provide services in a more rural areas is a dis-incentive for services to be provided in those areas. And I realize that perhaps they look at cost of providing service and that sort of thing, but I think really the present incentives are weighed too much contrary to our having supply out in the rural areas. So I really think that's a problem facing us.

I did mention the relative value. I call it the relative value. There's a fancier word for it, but the system that HCFA has contracted with the people at Harvard to develop. I don't know much about it. I've read a little about it, the preliminary reports on it. I think it would tend to encourage more primary care people in practice because it would increase their fees, and reduce the fees of some other types of specialists. And, of course, there could be a big fight in the medical profession over that because some are going to lose and some are going to gain.

Senator COCHRAN. Dr. Smith, you've heard my questions and Dr. Cobb's responses to how we try to encourage people to locate in areas where elderly people live and where, in the smaller towns, people are kind of going to be left out if they don't have hospitals and health care professionals. What are your observations about this issue area?

Dr. SMITH. I agree with Dr. Cobb, Senator Cochran, on the two primary things that I think that he has mentioned. Number one is that the AHEC, the Area Health Education Centers—this is a must for us, as far as I'm concerned. We need to get our young doctors back out in the community and have them experience the flavor of small town living. We need to have them become familiar with what the social problems are on the front lines, so to speak, in our towns and communities.

And my concern is that they may not be getting this in their educational program. I have no prior knowledge. There may be some rotation systems, but we're talking about long-term extended rotations into the smaller communities and also at the same time recruiting the physicians who are there to do the instruction on them. That's the faculty. They're the ones who should be certified and qualified to teach these young persons coming along.

The same is true, also, incidentally of other professions such as our nursing profession and that, incidentally, is an area that gives me great concern. We are going to feel a tremendous impact because of escalating wages in the Medicaid program because of the current nursing shortage. The resource based relative value scale that Dr. Cobb referred to, I think if this becomes practice in two or three years, will definitely enhance the worth of primary care services and should be pursued.

There is one option that was put into play several years ago simply to increase the number of medical school applicants, and I refer to the so-called capitation program. That was sponsored, as I recall, by the National Institute of Health, but this was a program that could be used today to give medical schools some kind of an enhancement to a reimbursement, some kind of a subsidization for ensuring that these young people then go back out into rural communities and practice. I think it's an idea that needs to be explored.

Senator **Cochran**. I noticed in your testimony you talked about expanding the availability to the elderly of some home health care services and other programs. Do you foresee any problems in getting Health Care Financing Administration approval of reimbursements that you have described, or is that expected?

Dr. **Smith**. I think that's expected. Many other states, for example, have gone much further with their home and community-based services waiver than we. For example, Oregon has developed this to an art form, so to speak. I was surprised to learn they only have something in the neighborhood of nine or ten thousand patients in nursing homes. They're doing mostly community-based services now. So it will work if it's put to the test.

Senator **Cochran**. Do we have any of these alternative congregate living facilities in our state? Have you done an assessment? You mentioned that as an alternative to nursing home care or hospital care.

Dr. **Smith**. We do have personal care homes. That's correct. We have homes for persons who are able to perform those activities of daily living and get around themselves without any special care. Coverage of those groups under Medicaid is an option that we do have, and we have not taken advantage of that in this state. I frankly don't see that as an immediate priority but more a priority a little bit further down the road because of some of the other priorities that we have.

Dr. **Cobb**. I might speak to that, Senator.

Senator **Cochran**. Yes.

Dr. **Cobb**. I think I mentioned that, too. I don't have an inventory of them, but there are a number of them, one right here. There's one in Greenwood I'm familiar with. There's several in Jackson. We don't have but one of the life care communities, and that is St. Catherine's (spelled phonetically) Village in Jackson and that's the only truly life care community in Mississippi.

But we have there in Jackson, the Orchard and several other very fine centers that provide high quality service. Those centers are mainly for patients who have the resources that can afford that level of care. But some of the advantage in that is that they can go in there and first have the apartment and then if they need personal care, its available. And then if they need nursing care, there's a nursing home component, and you have the tiered service system. And then you don't as likely misplace people and put people in nursing homes before they need to be in nursing homes.

Frankly, in many instances, we've had nursing homes as the only option because there's a payment system to cover nursing home care so there's pressure due to social problems and family problems and needs to place the client in a nursing home. So we've been pushed, those of us in administering these programs like Dr. Smith and I earlier had experience in, of approving placements that really were inappropriate. But frankly, it was the only option. It was all that was available and the family was no longer able to cope. So we put the individual in the nursing home, which really was more expensive and inappropriate.

I really think we need to look at specialized housing programs and apartments for the elderly. Many of them live alone, particularly in rural areas. I know they are reluctant to move. Many of them want to stay there as long as they can, but so often then when they have to move, it's very traumatic. I think our generation may be a little more inclined to move earlier and prepare ourselves rather than maybe persisting and staying at home beyond what's reasonable. I don't know how you cope with that when the individual wants to stay at home and the family wants to try to help them stay there. But in many instances, it would be wiser to go ahead and encourage a different type of housing earlier rather than staying out in the rural areas in their own homes.

Senator COCHRAN. Well, we have, I think, gotten a very good overview of our situation in Mississippi with regard to our resources for the delivery of health care to our elderly population from our two state officials who are here, and I want to again thank you for being here. I think your contributions to the hearing are very important and a good way to start off our hearing today. Thank you very, very much.

Our next panel will consist of witnesses who will discuss for us the role of our hospitals in making available care to the elderly citizens of our state. We have included in this panel John Hicks, who is president and chief executive officer of the North Mississippi Medical Center here in Tupelo; Clifford L. Johnson, Jr., who is executive director of the Northwest Mississippi Regional Medical Center in Clarksdale; Charles Shepherd, president and chief executive officer of H.C. Watkins Memorial Hospital in Quitman, Mississippi; and Sonja Jenkins, project director of Northeast Mississippi Rural Health Consortium in Tupelo.

We welcome you all to the hearing and thank you for agreeing to help us in our review of problems and challenges that we face here in Mississippi with a view toward the federal policies that affect our efforts to make available reasonably priced health care to our elderly citizens. We have statements which we thank you for, and they will all be included in the record in full. And we would encourage you to make summary statements orally and then that will give us a chance to discuss your impressions and your suggestions. Let's first hear from John Hicks. Mr. Hicks, you may proceed.

STATEMENTS OF JOHN D. HICKS, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NORTH MISSISSIPPI MEDICAL CENTER, TUPELO, MS; CLIFFORD L. JOHNSON, JR., EXECUTIVE DIRECTOR, NORTHWEST MISSISSIPPI REGIONAL MEDICAL CENTER, CLARKSDALE, MS; CHARLES SHEPHERD, PRESIDENT AND CHIEF EXECUTIVE OFFICER, H.C. WATKINS MEMORIAL HOSPITAL, QUITMAN, MS; AND SONJA JENKINS, PROJECT DIRECTOR, NORTHEAST MISSISSIPPI RURAL HEALTH CONSORTIUM

Mr. HICKS. Thank you, Senator Cochran. I appreciate your having this hearing and many of the people in this room know that since you've been in Congress you've always had an attentive ear and a thoughtful appreciation for the needs and issues of Mississippi hospitals and Mississippi physicians and nurses and those in the business of providing health care here. You and your staff have been helpful to those of us in Mississippi, and we appreciate that. We appreciate the opportunity to have this hearing.

Fifty years ago North Mississippi Medical Center was a 50-bed hospital with 39 employees. Today it is the largest hospital in rural America with twenty-two hundred employees, a medical staff of about a hundred and forty physicians who provide thirty-eight different medical and surgical specialty services. We are a 650 bed major specialized health center. Our population area is basically a 60-mile radius around Tupelo, which contains about five hundred fifty thousand people. Almost 13 percent of the patients that the Medical Center serves are 65 years of age or older and if our projections are correct, the number of the elderly that we will serve by the year 2000 will triple.

So we're certainly very much interested in the needs of the elderly today and the future plans and efforts that need to be underway to serve their needs in the future. We've been hard at work meeting the needs of the elderly, and I'd like to talk with you today about some of those programs that serve the elderly and to mention some of those obstacles that we face in meeting the needs of the elderly and other health care needs of the population.

Rural hospitals are in financial distress in Mississippi and across the United States of America. A recent survey by the Mississippi Hospital Association suggested that almost 50 out of 126 hospitals in the state are in serious financial distress. Perhaps what happened to the small corner drug store or the small corner grocery store is likely to be what will happen to the small community hospital. It likely will not survive as a traditional hospital. And as Dr. Cobb said, if it does not survive, what should be substituted in those communities to continue to provide health care?

I'd like to make some suggestions as to how these traditional small rural hospitals which may survive can be restructured, can be revitalized and can continue to even serve in a better capacity the health care needs of the elderly and the rest of the population. I want to speak about a regional health care system because I believe that a small rural hospital can survive and prosper if its role is changed and if it is a component of a regional health care system.

Now, this is not the single answer to the needs of rural hospitals, but I believe it is a significant answer that community hospitals link up with regional centers to function as a system serving the needs of the area. In our case, we are seeking to do that. North Mississippi Medical Center has specific agreements with six community hospitals, and those communities are Iuka, Mississippi; Baldwyn, Mississippi; Pontotoc; Fulton; Aberdeen and West Point.

We're seeking to develop a health care system with the Tupelo facility providing the specialized services and the community hospitals providing primary health care accessible for the elderly and the rest of the community. It used to be the community hospital tried to provide all services in its community. That's not true today, and I don't believe it's possible today. Health care technology is costly. It's not feasible for a community hospital to purchase high-tech equipment or to offer specialized medical services. But the rural hospital can be revitalized, and we are developing a model, we think a model, at least a system to look at the ways to convert the traditional rural hospital into a new viable resource. What would that resource provide for its citizenry? We think it certainly should provide emergency services, ambulance services, and that those should be coordinated. In our case we have a medical helicopter which can provide quick access within this 60 mile radius.

So emergency services certainly should be provided at the rural, what used to be called the hospital, and what I might now call health center or health resource. Diagnostic services can be made available at the rural health resource, basic lab and x-ray services so that citizens can have basic tests close to home, but the high-tech tests would occur at the regional referral center. Technology is developing to the point that many of the high-tech diagnostic services can now be made mobile, stuck on a van and moved around, in our case, to the six hospitals that function in our regional system.

And very, very importantly, the local family physician must be preserved and must survive in that local community. The citizens should not have to come to Tupelo or to Clarksdale or to Jackson or to Meridian, larger cities which might logically be regional centers. The citizens, the elderly, should not have to go to those regional centers for adequate, qualified primary health care. We are seeking in our system with these six other hospitals to develop a coordinated and planned recruitment effort to place family practice physicians at these rural hospitals.

One of the detractions to physicians going into a rural community is the thought in their mind that that local hospital may die and I won't then have the medical lab x-ray support that I need for the practice of medicine. Through our systems approach, we can provide support. We can provide assurance to the family practice physician that the things that he needs to take care of his patients will be available in that center, although a traditional hospital, as such, may no longer be there. We believe this regional system which I've just given a thumbnail sketch of can serve as a model throughout Mississippi and throughout the United States of America.

There are some other innovative programs that we're trying to develop through this regional system to meet the needs of the elderly. We're looking to convert hospital beds that are not needed in Pontotoc, for example, into services that are needed.

Let me suggest several of those services that are needed and that can work in the small rural hospital: The swing bed program. In 1983, North Mississippi Medical Center was one of the first sites in America where a new concept was developed, was approved, and it is working. It's called the swing bed program. All hospital beds are classified and many times there exists a gap between the classification of beds. You have acute hospital beds, the type we have at this facility here. You have extended nursing home beds, and in between those two types of beds is a gap with patients who have needs, yet don't fit into either category.

We suggested to the State of Mississippi that we be permitted to be licensed as a swing bed program to sort of swing back and forth between these classifications to meet that need, to develop a new classification, if you will. That program was approved. We have a program going at our Baldwyn hospital and we are now, with the support of the State of Mississippi and the licensing agency, developing additional swing bed programs at these five other rural hospitals that we're working with.

Home care has been mentioned by Dr. Smith. Home care, whether it's provided by the local health department or by the local hospital or provided by an entrepreneurial group, is a much needed program. North Mississippi Medical Center has a home care program today that we are now moving out from the regional hospital to the smaller hospitals in the region, such as in Baldwyn and in Fulton so that we can have local home care offices throughout the region. This week we have about 460 patients receiving home care services, either nurses visiting them or maybe I.V. therapy that can be done in the home, rather than in the expensive hospitals.

Physical therapists are doing exercise treatments in the home rather than in an expensive hospital and those 460 patients receiving those services in the absence of home care would probably either be in somebody's hospital or would not be receiving the services that they need to recover.

Personal care facilities. We are working with the Aberdeen-Monroe County Hospital, one of our six affiliates, to convert 36 beds that are not being used into twelve beds of efficiency apartments, personal home care, whatever banner or title we want to call them. These are elderly residents who are not ill. They are retired, and why not use the security, the nice facilities and the empty space of a hospital converted to efficiency apartments? These elderly people do want laundry, housekeeping and dietary services. They do not need nursing services. So by March of next year, 1989, we will have that conversion complete.

Now, it's interesting that the one reason that the board of directors of the Aberdeen-Monroe County Hospital chose to affiliate with North Mississippi Medical Center is that that hospital had a good idea but did not have the financial strength to make the conversion, which is one of the problems that rural hospitals have. They have good ideas but they're financially stressed and it takes financial resources to convert, to move from where you are to where you might be. In this case the Medical Center is providing the financial assistance and it's a proper role for us to play to help make that conversion.

There is an acute need for additional nursing homes. In the State of Mississippi our hands are somewhat tied because there is a state moratorium on nursing homes which has existed for the last eight years. So essentially outside of a few exceptions that did permit some very small expansion of a few nursing homes, Outside of that there has been a moratorium in Mississippi at a time when the need for nursing homes is growing. Hospitals, unused hospital beds in rural communities, particularly, could be converted to nursing homes. Based on our research, we believe that there will be a doubling of the number of nursing home beds that will be needed by the year 2000, a doubling of what existed at least in 1980, which is a late count. So as we look to the future to meet the health care needs, I'm suggesting that a regional health care system is one way to restructure the rural hospital. We're doing a lot of work here, Senator Cochran, and continuing to evolve and develop as that hub of what might be a regional system through a project that we call Project 90, which by its name indicates that we seek to be prepared to take care of the needs of the elderly and our other patients during the decade of the nineties. We're expanding our heart programs, our cancer programs.

But as we look to the expansion of services here at this medical center and as we work to develop and to restructure a regional system that involves these six and potentially other rural hospitals, there are several factors which cloud our vision of the future. Specifically, the future is clouded by the ever-growing inadequate funding of both rural and urban hospitals under the Medicare program. Over the last several years, North Mississippi Medical Center and these other six hospitals have received increases in our Medicare funding in the neighborhood of 1 to 2 percent each year, but the cost of operating a hospital and of having nurses and staffing and providing supplies is increasing in the neighborhood of 8 to 10 percent a year. There is, therefore, a terrible short fall in the funds provided by Medicare compared to what it costs to take care of the elderly population.

In 1988, at this medical center, North Mississippi Medical Center provided discounts to the Medicare program totaling 29 million dollars. And let me see if I can clearly define what a discount is. If it takes us one dollar to take care of the elderly patient, one dollar to take care of that patient and the Medicare pays us 55 cents, then we've provided a 45 cent "discount" to the Medicare program. That 45 cent on every dollar all totaled was 29 million dollars last year at this medical center. Next year it will be 37 million dollars. And if this rate continues by 1997, North Mississippi Medical Center will be providing discounts to the Medicare program of 224 million dollars. In Mississippi that's a lot of money.

The other side of this problem, there's two problems, that Medicare is not paying its fair share for the services that we provide the elderly that creates the financial distress that hospitals have. That's problem number one. The concomitant problem number two is that hospitals must charge somebody for those services in order to keep our doors open. So we take the 45 cents on every dollar that Medicare does not pay and add it to the bill of those patients with insurance to those companies who have insurance plans for their employees, so they now pay a dollar and 45 cents for every dollar's worth of care that they receive.

Now, what I just described is not illegal. Whether it's correct sociatal policy, I say that it isn't. It's cost shifting and it is the single most important factor that is creating the heath care cost concern by the folks who do pay for their health care: business, industry and insurance companies. It is the short fall payments on the government's side that cause the excessive costs, the high charges on the private side. Medicare programs are jeopardizing the financial strengths of rural hospitals, small and large.

Let me suggest several solutions. It is my hope that Congress would act to more adequately fund the Medicare program and to equalize the payments, received by urban and rural hospitals. I would personally encourage the Secretary of Health and Human Services to do more studies comparing the cost of rural versus metropolitan hospitals and of particular interest to North Mississippi Medical Center is the concept of these regional hospitals like ours of 650 beds which in every way function as metropolitan hospitals, but we're just fortunate enough to be located in a non-SMA location. We're fortunate enough to be located in rural Mississippi, and we're glad we're located here. We'd like, though, for serious analysis to be done regarding that rural/urban reimbursement differential of the Medicare program.

Number two, I would like to support and advocate that Congress provide additional funding for the training of family practice physicians. Dr. Smith and Dr. Cobb both touched on this. We may not need federal support for funding of cardiovascular surgeons. I don't know. But I do know that we need congressional support for training of family practice physicians to place them in rural America.

And number three, I would suggest that we do need a national policy addressing the nursing home needs. Most nursing home regulations are state run and operated. Perhaps that's appropriate, but I believe that a federal policy is needed to assure an adequate number of nursing home beds for the future.

If rural hospitals fail and if rural hospitals close, then it is the elderly who are most denied convenient access to health care. As a health care provider, I don't want to see that happen.

I believe that the federal government should ease the financial burden of small and large rural hospitals alike and that it would be very appropriate for the federal government to strengthen its support for family practice physician training programs and to develop a national policy to prepare for the future as well as the current needs for nursing home facilities for the elderly.

[The prepared statement of Mr. Hicks follows:]

U.S. SENATE SUBCOMMITTEE ON AGING
HEARING: TUPELO, MISSISSIPPI
"ELDERLY HEALTH CARE IN MISSISSIPPI"
OCTOBER 20, 1988

COMMENTS FROM JOHN D. HICKS
PRESIDENT/CEO
NORTH MISSISSIPPI MEDICAL CENTER
TUPELO, MISSISSIPPI

OPENING STATEMENT

Since North Mississippi Medical Center opened its doors 50 years ago, it has grown from a 50-bed hospital with 39 employees, to become the largest non-metropolitan hospital in America. With more than 2,000 employees, NMMC is a 650-bed, not-for-profit, tertiary medical center. We serve a population area of approximately 550,000 people living in North Mississippi, Northwest Alabama, and Southwest Tennessee. We have 141 physicians on staff who represent 38 medical and surgical specialties.

Almost 13 percent of the population we serve is 65 years old or older. And if projections hold true for our service area, the number of elderly persons we serve will triple by the year 2000.

As a health care provider, North Mississippi Medical Center has worked to meet the needs of the increasing "graying population". Today, I want to share with you those needs, and I want to address some of the obstacles we face in meeting those needs.

BUILDING A REGIONAL HEALTH CARE SYSTEM

Just like the small drug store or grocery store, the small, autonomous rural hospital can not survive as a traditional hospital.

1. Organization of A Regional Health Care System -- As a component of a regional system, the small rural hospital can survive and prosper if its role is changed. NMMC serves as the hub. Six community hospitals serve as the spokes. The small rural hospital provides convenient access to primary care for residents of the community, particularly the elderly. NMMC provides specialty care and coordinates the system.

2. Changing role of the community hospital -- It used to be that the community hospital could do almost everything for the patient. That's not true anymore. New technology is costly; thus, it is not feasible for community hospitals to purchase high-tech equipment or to offer specialized services.

3. Revitalizing the community hospital -- We are looking at ways to convert the traditional community hospital into a new, viable resource to meet the health care needs of the elderly and the entire rural population.

A. Minor emergency services -- The small hospital will not perform surgery or deliver babies. It can provide minor emergency services and ambulance services. These emergency services will be directly tied into NMMC's major trauma and emergency service. Our helicopter and ground ambulance services provide quicker access.

B. Diagnostic services -- The rural hospital will have basic lab and X-ray services available, as well as other basic diagnostic capabilities. Some high-tech diagnostic services will become mobile to move from NMMC to the affiliate hospitals.

C. Family physicians must survive -- Very importantly, the local family practice physician must be preserved in the rural communities. NMMC and the affiliate hospitals have developed a coordinated and planned recruitment program to place additional family practice physicians at the rural hospitals. These physicians will refer patients needing specialized services to NMMC.

We believe this regional system can work and will serve as a model for other areas throughout the United States.

INNOVATIVE PROGRAMS FOR THE ELDERLY

To help meet the growing needs of the elderly, we have implemented some innovative programs at our affiliate hospitals to meet the needs of the elderly, and at the same time to strengthen the rural hospitals by converting unused beds to new programs.

1. Swing Bed Program -- In 1983, the State of Mississippi licensed 10 beds at our Baldwyn Hospital to start a swing bed program. ("Swing Bed" refers to a hospital room or "bed" which can be utilized for acute care or for skilled care. If the patient's condition changes, the level of care "swings" to meet the patient's need.) The swing bed program at Baldwyn was so successful that it now serves as a model program for rural hospitals throughout the country. Currently, we have implemented swing bed programs at all our affiliate hospitals.

2. Personal Care Facility -- Aberdeen-Monroe County Hospital is converting 36 beds into a 12-apartment personal care facility. The efficiency apartments will serve retirees who continue to lead an active lifestyle. Because the residents will be healthy and active, nursing services will not be necessary. But the hospital will provide dietary, laundry, and housekeeping services. It is scheduled to open in March 1989.

3. Nursing Homes -- We operate nursing homes at our Baldwyn and Pontotoc hospitals. We feel that converting empty hospital beds to nursing home beds would be a cost-efficient way for us to put those beds to use, and at the same time serve a much-needed purpose for the growing elderly population. However, our hands are tied because of a state moratorium on the nursing home beds the past eight years.

Nearly 29 million Americans, or 12 percent, of the population is 65 years or older. By the year 2000, the number of people over age 65 will increase to 36 million. It is estimated that by the year 2000, there will be 3.1 million nursing home residents -- a 103 percent increase from the 1980 nursing home bed count of 1.5 million.

VISION FOR THE FUTURE

In order to meet the region's health care needs of tomorrow, NMMC has begun implementing an ambitious five-year expansion program. Project 90 is a response to needs for enhancing outpatient services, additional inpatient services, new technology, and patient amenities.

Among the expansion projects we have recently completed are a cardiology center, a 30-bed inpatient rehabilitation center, two new floors to the patient bedtower, and an off-site services center. Upcoming projects we plan to build include an education center, an outpatient oncology center, and an expanded behavioral health center.

INADEQUATE MEDICARE FUNDING

Our vision for the future is clouded with the ever-growing inadequate funding that both rural and urban hospitals are incurring from Medicare payments.

1. DRG reimbursements -- We are seeing only 1% - 2% increase in reimbursements each year, yet our cost for delivering quality health care this past year jumped by 8 percent.

   To our knowledge, no study has been conducted which addresses the specific characteristics and costs of rural hospitals having 500 beds or more. There have been studies which addressed the impact of the reimbursement system on rural hospitals, but the 500-bed rural hospitals were lumped together with hospitals having as few as 170 beds for the purposes of the analyses.

2. 1988 and 1989 Medicare discounts -- In 1988, discounts to the Medicare Program totaled $29 million at NMMC. It is projected that next year those discounts will jump to $37 million. We are forced to pass on those costs to our private patients. If the Medicare allowances continue to grow at the average annual growth rate of 27.4%, we will be writing off $224 million in Medicare discounts in 1997.

3. Current Medicare programs are jeopardizing the financial strength of community hospitals -- Medicare patients utilize sixty percent of the patient days at our affiliate hospitals. Medicaid patients utilize another 10 percent. Private patients, who make up the remaining 30 percent, simply cannot carry the weight of making up the difference.

SOLUTIONS

1. It is our hope that Congress will act to more adequately fund the Medicare program and to equalize metropolitan and rural DRG reimbursements. Specifically, we would encourage the Secretary of Health and Human Services to conduct a study of rural hospitals having at least 500 beds to determine whether those hospitals should be classified as urban hospitals for reimbursement purposes.

2. We hope that through medical education programs, Congress will continue to support the training of family practice physicians, so desperately needed in rural America.

3. A national policy addressing nursing home care needs to be devised.

CLOSING STATEMENT

As the "graying" population continues to grow, we will see an increased number of chronic conditions requiring health care. No matter how many cost containment measures the government takes, Medicare costs will continue to increase simply because more people will need more services.

If a rural hospital fails and is forced to close its doors to its community, the elderly will be the primary group which is denied convenient access to health care services.

As a health care provider system, we do not want that to happen. We believe the federal government should help ease our financial burden by providing more reasonable Medicare payments to our hospitals so that we may continue to offer innovative, convenient, and quality health care services to our elderly population. And we believe the Congress should develop a national policy so the nation is prepared to provide nursing home facilities adequate to meet the needs in the future.

Senator COCHRAN. Thank you very much, John Hicks, for your excellent presentation, very helpful, very informative, thought-provoking and in every way a very important contribution to our hearing today. Let me now call on Mr. Johnson, Clifford Johnson, who has provided us with a statement for our hearing. We will include this in the record of the hearing and encourage you to summarize your statements for us so we'll have a chance to ask questions of the panel. Clifford Johnson, Jr. is the executive director of the Northwest Mississippi Regional Medical Center at Clarksdale.

Mr. JOHNSON. Thank you, Senator Cochran. I appreciate the interest that you're taking in the health care issues and especially in rural health, and I feel that something is really going to be done about this issue with your help?

There are many issues impacting on the elderly as they relate to the health care industry, but this morning I want primarily to address only one. That is the matter of uncompensated care caused by the inequities in federal reimbursement under the Prospective Payment System and the threat that this imposes on rural hospitals. I'd like to begin my remarks by issuing a warning. Accessibility to health care for millions of Americans is being jeopardized, particularly for the poor and for the elderly. Payment under the DRG system, which is inadequate and other unfair reimbursement guidelines pertaining to urban and rural hospitals are creating such enormous financial burdens on rural hospitals that a bona fide crisis is at our door.

To be able to go to your local community hospital is a given in this country, and I think everybody agrees with that. It's something so basic to our way of life that it is literally taken for granted. But the toll of recent federal reimbursements changes is being tallied and hospitals are closing all over this country, particularly rural hospitals which have a heavy Medicare/Medicaid utilization.

But let me bring this down to the case of one hospital, Northwest Mississippi Regional Medical Center in Clarksdale. We are a 194-bed fully accredited county owned hospital. We have over 50 doctors on our medical staff—50 percent of whom are Board Certified specialists. We have all of the state of the art technology that is commensurate with being a regional referral center. And by the way, the federal government does not recognize us as a regional referral center because of some of their technicalities. We're absolutely key to the viability of life in Coahoma County in every sense of the word.

Last year we billed our patients over 32 million dollars for services. That figure in 1980 was about half that amount. We charged off of that figure 11 million dollars. That figure in 1980 was 1.9 million. We charged off 36 percent of what we billed our patients. This is called uncompensated care. To those that don't know what uncompensated care is, uncompensated care is the amount of health care that is rendered for which payment is not forthcoming that we don't expect to receive from either the person receiving the care or from the third party payer. The biggest factor in our uncompensated care losses is the difference between the cost of care and reimbursement for care from Medicare.

We calculated that we have to give away every service that we provide for the first four months of every year before we get to keep anything for ourselves. How many businesses do you know of that could operate with this kind of financial havoc.

Over 50 percent of our patients are Medicare recipients; 16.8 percent are Medicaid. This means that 69 percent of our business is dependent on federal reimbursement programs. Those are staggering figures and certainly are not indicative of the normal financial mix in all Mississippi hospitals, but let me compound the problem by telling you that on the average our hospital loses 50 percent on every DRG. If it costs us four thousand dollars to treat a Medicare patient suffering from heart failure or shock, we get two thousand dollars. During the most recent quarter, we treated 741 Medicare patients with an average charge of four thousand six hundred and eighty-four dollars. We were reimbursed two thousand one hundred eighty-five dollars. That's less than 50 percent of what we billed.

DRG's were initially established to cover a reasonable amount of the cost of providing care. On the average, though, they do not. The DRG system of payment is equitable only when patients do not remain hospitalized very long and do not utilize very many hospital services. But let's face reality. People over 65 years of age have more health problems. They become hospitalized more frequently and are sicker and require a greater intensity of hospital services, so that's a real problem.

But there's more and this might be a little technical, but just bear with me. Included in the Medicare guidelines is a provision for add-on DRG reimbursement in hospitals like ours which care for a disproportionate share of federal patients. This add-on payment is calculated according to an urban/rural formula. But the rub is that urban hospital and rural hospitals are paid quite differently. I've provided documentation in my handout that go into this into a lot more detail. But the bottom line is this, that an urban hospital has to provide less indigent care to get a higher add-on payment than a rural hospital. The rural hospitals are discriminated against and are required to provide more indigent care to get a lesser percentage of add-on pay. That sounds complicated but in dollars and cents this is how it translates.

If the Medical Center in Clarksdale had been referring the same percentage of disproportionate share add-ons as an urban facility with like patient mix, our payment would have gone from a hundred and ninety-seven thousand dollars to over seven hundred thirty-eight thousand dollars last year. We don't think that's fair. I'm not picking on my friends in Jackson, but I believe that it costs us as much to treat pneumonia in Clarksdale as it does in Jackson. Yet simply by virtue of hospitals existing in an urban area, that facility gets a higher reimbursement and we feel like that this is discriminatory and it's unfair. And it needs to be changed.

In the same vein, labor rates are calculated along urban and rural lines. All urban hospitals have an individual wage index factor, but the rural hospitals are all lumped together under one rural rate. This is blatantly unfair in that the services rendered in rural hospital differ drastically from very sophisticated facilities such as ours to small rural hospitals that are a little more than first aid stations. In dollars and cents, the Medical Center in Clarksdale would have received eight hundred six thousand dollars more during fiscal year 1987 if we had been paid at the same rate as urban hospitals in Jackson.

Taking into consideration all reimbursement guidelines that are differentiated along urban and rural lines, our rural hospital would have received an additional one million two hundred thousand dollars, excluding the increase for wage indexes that I just mentioned if it had been paid on the urban rates. That figure's almost three million dollars, by the way. In Clarksdale, Mississippi, a million dollars makes a critical difference in our ability to stay alive, and that's where we need help.

Getting away from reimbursement for just a few minutes, we're here to share problems and ideas that affect the quality of life for all of our older citizens and in getting ready for this program, I spoke with my staff of Social Service people and Utilization Review people. And they tell me how frustrated they are with the problem that they face everyday and that's the need for transportation services for the elderly.

There are five different agencies which provide transportation to elderly in Coahoma County, but the guidelines of these respective services are so structured that they fail to meet some basic daily needs: (1) Transportation services are offered only on certain days of the week or are not permitted to cross county lines to a regional referral center. (2) The services are not set up to handle unscheduled requests such as transportation to the doctor and the hospital for out-patient services or transportation to and from nursing homes to visit a spouse or a family member or transportation from the hospital following discharge.

Lack of transportation often extends a Medicare patient's hospital stay because of this. In Clarksdale it may cost an elderly person fifteen to twenty-five dollars for transportation outside the county. Our social work department received approximately 125 requests for transportation this part year. Transportation services are crucial to the elderly population's accessibility to not only health care but to all community services.

There are other areas of concern that John mentioned such as nursing homes and home health services, but those are covered by the moratorium and the State of Mississippi and we really can't do a lot about that.

Senator Cochran, if the Congress of the United States does not quickly respond to the inequities in the Medicare program that I have just outlined, then a genuine threat exists to those hospitals that fall in the rural and disproportionate share categories. What I'm concerned about is the possible failure of the health care system in grassroots' America. If you think it costs money to maintain a quality hospital in today's marketplace, and we all know that it does, I cannot imagine the cost to the American taxpayer in trying to resurrect a health care system that has been allowed to fail through default.

I was asked recently by a member of the press why I thought hospitals were any different from other causes which are threatened by federal budget cuts. It should be clear that hospitals deal in the unique and fragile commodity of human life. There's no margin for error for us, so we must prevail. And we therefore ask you for your help.

[The prepared statement of Mr. Johnson follows:]

PRESENTATION TO HONORABLE THAD COCHRAN
U.S. SENATE SUBCOMMITTEE ON AGING/ OCTOBER 20, 1988

By

CLIFFORD L. JOHNSON, JR., FACHE, EXECUTIVE DIRECTOR
NORTHWEST MISSISSIPPI REGIONAL MEDICAL CENTER
Clarksdale, MS 38614

There are many issues impacting on the elderly as they relate to the healthcare industry - but this morning I want primarily to address only one; The matter of uncompensated care caused by inequities in federal reimbursement under the Prospective Payment System (DRG's) and the threat this imposes on rural hospitals.

I would like to begin my remarks by issuing a warning: Accessibility to healthcare for millions of Americans is being jeopardized - particularly for the poor and elderly. Payment under the DRG system (which is inadequate) and other unfair reimbursement guidelines pertaining to urban and rural hospitals are creating such enormous financial burdens on rural hospitals that a bona fide crisis is at our door.

To be able to go to your local community hospital is a "given" in this country.... something so basic to our way of life that it is literally taken for granted. But the toll of recent federal reimbursement changes is being tallied, and hospitals are closing all over this country - particularly rural hospitals which have a heavy Medicare/Medicaid utilization.

Let me bring this down to the case of the Northwest Mississippi Regional Medical Center in Clarksdale. We are a 194-bed fully accredited, county-owned hospital. We have over 50 doctors on the medical staff, 50% of whom are Board Certified specialists. We have all the state-of-the-art technology that is commensurate with being a regional referral center. We are absolutely key to the viability of life in Coahoma County in every sense of the word.

Last year we billed over $32,000,000 for services. Sounds promising, doesn't it! But we had to charge off over $11,000,000 in UNCOMPENSATED CARE. That's 36% of our business. Uncompensated Care is the amount of healthcare rendered for which payment is not forthcoming from either the person receiving the care or a third party payor. The biggest factor in our uncompensated care losses is the difference between the cost of care and reimbursement for care from Medicare.

We calculated that we have to give away every service we provide for the first four months of the year before we get to keep anything for ourselves. How many businesses do you know that can operate with this kind of financial havoc!

Over 50% of of our patients are Medicare recipients - 16.8% are Medicaid. This means that 69% of our business is dependent on federal program reimbursement. Now those are staggering figures and certainly not indicative of the normal financial mix in Missisisppi hospitals.

Let me compound the problem by telling you that on the average, our hospital loses 50% on every DRG. If it costs us $4,000 to treat a Medicare patient suffering from heart failure and shock, we get paid $2,000. During the most recent quarter, we treated 741 Medicare patients with an average charge of $4,684. We were reimbursed $2,185. That's LESS than 50% of cost!

DRG's were initially established to cover a "reasonable" amount of the cost of providing care. On the average, they do not. The DRG system of payment is equitable ONLY when patients do not remain hospitalized very long and do not utilize very many hospital services. But let's face reality. People over 65 years of age have MORE health problems; become hospitalized MORE frequently; are SICKER and require a GREATER intensity of hospital services. You see the problem.

There's more. This is a little technical, but bear with me. Included in the Medicare guidelines is a provision for add-on DRG reimbursement in hospitals like ours which care for a Disproportionate Share of federal patients. This add-on payment is calculated according to an Urban/Rural formula. The rub is that urban hospitals and rural hospitals are paid quite differently. I've provided documentation to you on the specifics of these Disproportionate Share Add-ons, but the bottom line is this:

An urban hospital has to provide less indigent care to get a higher add-on payment than a rural hospital. The rural hospitals are discriminated against and required to provide more indigent care to get a lesser percentage of add-on pay. Now that sounds complicated, but in dollars and cents this is how it translates:

If the Medical Center in Clarksdale had been receiving the same percentage of disproportionate share add-ons as an urban facility with like patient mix, our payment would have [illegible] from $197,000 to over $738,000 last year. Folks, that's no [illegible]! I'm not picking on my friend, Bob Wilson, at Hinds General; but I believe that it costs us as much to treat pneumonia in Clarksdale as it does in Jackson. Yet simply by virtue of a hospital's existing in an urban area, that facility gets a higher reimbursement. This is discriminatory; this is unfair; it needs to be changed.

In the same vein, labor rates are calculated along urban and rural lines. All URBAN hospitals have an individual wage index factor. RURAL hospitals are lumped together into one index.

This is blatantly unfair in that the services rendered in rural hospitals differ drastically from very sophisticated facilities like ours to small rural hospital that are little more than first aid stations. In dollars and cents, the Medical Center in Clarksdale would have received $806,000 more during FY 1987 if we had been paid at the same rate as urban hospitals in Jackson.

Taking into consideration all reimbursement guidelines that are differentiated along urban/rural lines, our rural hospital would have received an additional $1,200,000 (excluding the increase for wage index discussed above) IF it had been paid on the urban rates. In Clarksdale, MS, a million dollars makes a critical difference in our ability to stay alive. We need help here.

We are here to share problems and ideas that affect the quality of life for our older citizens. In getting ready for this program today, I spoke with the staff of my Social Service and Utilization Review Departments. They tell me how frustrated they are with a problem they face every day - the need for transportation services for the elderly. There are five different agencies which provide transportation to elderly in Coahoma County, but the guidelines of these respective services are so structured that they fail to meet some basic, daily needs:

1. Transportation services are offered only on certain days of the week or are not permitted to cross county lines to a regional referral center.
2. The services are not set up to handle unscheduled requests (e.g., transportation to the doctor and hospital for outpatient services; transportation to and from nursing homes to visit a spouse or family member; transportation from the hospital following discharge).

Lack of transportation often extends a Medicare patient's hospital stay because family members refuse to place the patient in a long-term facility outside the home county because there is no way to visit that loved one. In Clarksdale it may cost an elderly person $15 - $25 for transportation outside the county. Our Social Work Department has received approximately 125 requests for transportation this past year. Transportation services are crucial to the elderly population's accessibility to community services.

Other areas of concern are the shortage of nursing home beds and home health services. It's time for our state to lift the moratorium on these two entities. Yesterday, our hosital made 52 telephone calls trying to locate one nursing home bed. The government is pressing us toward shorter hospital stays and greater utilization of outpatient services. An increase in nursing home beds and home health services would make this a much more viable option because physicians would be assured of acceptable follow-up care after discharge.

Senator Cochran, if the Congress of the United States does not quickly respond to the inequities in the Medicare program I have outlined today, then a genuine threat exists to those hospitals that fall in the rural and disproportionate share categories. What I am concerned about is the possible failure of the healthcare system in grassroots' American. If you think it costs money to maintain a quality hospital in today's marketplace (and it does), I cannot imagine the cost to the American taxpayer in trying to resurrect a healthcare system that has been allowed to fail through default.

I was asked recently by a member of the press why I thought hospitals were any different from other "causes" which are threatened by federal budget cuts. It should be clear that hospitals deal in the unique and fragile commodity of human life. There IS no margin of error for us. We must prevail. We ask for your help.

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Clifford L. Johnson, Jr., FACHE
Executive Director

October 20, 1988

The Honorable Thad Cochran
United States Senator
Washington, DC 20510

Dear Senator Cochran:

I appreciate the opportunity to meet with you today in Tupelo and share with you my concerns about some of the inequities in the Medicare Prospective Payment System, particularly those which adversely affect rural hospitals. As the administrator of a 194-bed hospital in Clarksdale, Mississippi, I am struggling with what amounts to discrimination in the following areas:

1) The Disproportionate Share Add-ons
2) The Labor Related and Non-Labor Related Factors

The Disproportionate Share Add-on is calculated by adding the percentage of the number of Medicaid patients seen plus the percentge of Medicare patients who draw SSI.

At the present time disproportionate share payments are determined as follows:

Rural hospitals must have 45% indigent patients to qualify for a 4% add-on payment

Urban hospitals need only have 40% indigent patients to quality for a 15% add-on payment

In addition, Urban hospitals start drawing the disproportionate share add-on with a 15% indigent patient load (where they draw a 2 1/2% share add-on) and the add-on is then graduated up to the 40% / 15% level.

For FY 1987 the Northwest Mississippi Regional Medical Center received $197,044 as a Disproportionate Share Adjustment. This amount to 4% of the federal portion of the DRG payment.

If the NWMRMC had been receiving the same percentage as an urban facility with the same percentage of low-income patients as admitted here, the amount of the Disproportionate Share Adjustment would have been $738,915.

Turning our attention to the matter of labor rates, I would like to point out that all urban areas have an individual wage index, while rural areas are grouped by state. The following is a list of the discrepancies in the wage index for urban and rural areas:

Memphis, TN	.9644
Jackson, MS	.8439
Biloxi-Gulfport, MS	.8012
All Rural MS Hospitals	.7215

If the NWMRMC were receiving payments based on the same rate as an urban hospital in Jackson, MS, each discharged patient would have generated approximately $260.00 additional payment. **This would have translated into approximately $806,780 during FY 1987.**

Two other components that go into the calculation of a DRG payment are the labor related and non-labor related factors. These are set by HCFA and are broken down between urban and rural hospitals. This breakdown is as follows:

URBAN		RURAL	
LABOR RELATED	NON-LABOR RELATED	LABOR RELATED	NON-LABOR RELATED
2337.09	828.12	2123.20	587.97

If our rural hospital in Clarksdale, MS, had been treated equally to urban hospitals during FY 1987, the NWMRMC would have received an additional $1,224,040 excluding the increase for the wage index calculated above.

Senator Cochran, rural hospitals in America will not prevail unless the federal programs that aid the urban hospitals at the expense of the rural hospitals are changed. Unless the form of discrimination illustrated above is ended, rural America will soon have to find transportation to urban areas for the healthcare that is needed. Why have rural hospitals been so forgotten! There are more rural hospitals in this country than urban, but they are no match for the corporate giants of the cities. I think it is time for the representatives of rural hospitals to stand up and be counted in Washington.

I would now like to move to the area of wage index. The first column below reflects the difference between the wage index for urban and rural facilities. The amounts given are the additional amounts that would have been received by the various facilities if they had received the same rates as an urban facility.

The second column reflects the difference between the Labor and Non-labor related factors. The amounts given reflect the increased dollars that would have been received if the rural facility had been paid as an urban facility.

The third column reflects the difference between the disproportionate share paid to urban and rural facilities. These amounts reflect additional dollars that would have been received if the rural facility received the same disproportionate share percentage as an urban facility.

HOSPITALS	WAGE INDEX	LABOR/NON-LABOR FACTORS	DISPROPORTIONATE SHARE
NORTHWEST	806,780	1,224,040	738,915
BOLIVAR CO.	482,040	624,840	407,074
SO. SUNFLOWER	132,916	243,656	213,725
K'S DAUGHTERS	271,700	412,775	----
G'WOOD LEFLORE	827,580	1,253,783	548,317
DELTA MEDICAL	571,081	2,799,878	----

Senator Cochran, I feel the figures speak for themselves. There are clearly major inequities in the reimbursement system to hospitals under the PPS system.

There is still another area that concerns me. I am told that Washington has documented evidence showing it costs more to operate an urban hospital than a rural one. However, we looked at cost in our hospital and compared it to urbans in our area and do NOT find this to be the case. I think it is a matter of services provided; and therefore ALL hospitals should be looked at on an individual basis rather than to have all rural hospitals included in one group, as they are in Mississippi.

The table below will show the difference in some supply costs between our hospital and urban hospitals in our area:

DESCRIPTION	OUR COSTS	URBAN HOSPITALS
Medtronic #5985 Pacemaker	$ 3,700.00	$2,800.00
Medtronic #4011-58 Lead	650.00	585.00
DuPont Film 14 x 17	146.29/bx	140.45/bx
Disp. Lap Pack J&J #1259	12.40/ea	10.19/ea
Surgeons Gloves, Travenol	14.75/bx	13.00/bx
IV Placement Units Jelco	1.33/ea	.60/ea
Lab Reagents:		
Abbott HCG Urine Beta	90.00/ea	85.00/ea
Abbott Phenbarbital Kit	305.00/ea	245.00/ea

In order to help the rural hospitals, I would like to make the following recommendations:

1) Disporportionate Share Add-ons be made equal by bringing the rural hospital rate up to the ruban rate or by equalizing the rate between the two. We do not see the need to differentiate between rural and urbans. This rate should be based solely on the percentage of indigent patients taken care of by a particular hospital.

2) Increase the Labor and Non-labor factors in the PPS rate, bringing the rural hospitals up to the urban hospitals' level or by making the urban rates and the rural rates equal somewhere in the middle.

3) Totally abandon the Wage Index Rate that is currently being used in the computation of the PPS rate.

I appreciate your time and interest in our needs and will keep you informed about other areas of concern under separate cover.

Sincerely,

NORTHWEST MISSISSIPPI REGIONAL MEDICAL CENTER

Clifford J. Johnson jr

Clifford L. Johnson, Jr., FACHE
Executive Director

CLJjr:cj

0042 NW MS REG. MED. CENTER, CLARKS   MISSISSIPPI FOUNDATION FOR MEDICAL CARE   RUN DATE 07/05/88

HOSPITAL DRG PROFILE

01/01/88 THRU 03/31/88

DRG	TITLE	GEOM ALOS	RNK	CASES	ALOS	%DAY OUTL	AVG CHARGES	AVG REIMB	% DISCHARGED TO HOM	TRANS	LTC	EXP	OTH
127	HEART FAILURE & SHOCK	6.7	01	51	7.0	01	3724.37	1717.88	80	01	07	07	01
140	ANGINA PECTORIS	4.6	02	41	5.4	04	2716.55	1057.54	90	04	02	02	00
182	ESOPHAGITIS,GASTROENT& MISC DIGEST DIS AGE 70+ &/OR C.	4.7	03	26	5.0	00	2221.00	1055.14	92	03	03	00	00
096	BRONCHITIS & ASTHMA AGE >=70 AND/OR C.C.	6.0	04	25	7.5	04	3707.14	1615.64	88	00	08	04	00
014	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	8.5	05	23	13.4	17	5506.28	2495.23	60	13	17	04	04
015	TRANSIENT ISCHEMIC ATTACKS AND PRECEREBRAL OCCLUSIONS	4.6	06	22	6.9	00	2886.60	912.88	90	04	04	00	00
089	SIMPLE PNEUMONIA & PLEURISY AGE >=70 AND/OR C.C.	7.5	07	21	8.2	04	4623.60	2430.39	71	00	00	23	04
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS AGE 70+ &/OR	4.9	08	20	7.9	10	3495.43	1404.06	85	05	00	10	00
468	UNRELATED OR PROC	11.5	09	19	13.5	05	10598.41	5414.80	78	00	00	21	00
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 70+ &/OR C.	6.0	10	18	9.7	11	4168.47	1875.91	61	00	22	16	00
320	KIDNEY & URINARY TRACT INFECTIONS AGE >=70 AND/OR C.C.	6.5	11	12	9.8	00	4572.14	1730.44	100	00	00	00	00
079	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 70+ &/OR C.	9.6	12	11	19.2	09	10430.04	4951.89	81	00	09	09	00
210	HIP & FEMUR PROCS EXCEPT MAJOR JOINT AGE 70+ &/OR C.C.	14.7	13	11	16.5	09	9091.98	4205.63	36	18	36	09	00
243	MEDICAL BACK PROBLEMS	6.2	14	10	8.7	10	2911.30	1219.14	70	00	30	00	00
341	PENIS PROCEDURES	4.3	15	10	5.7	00	3853.81	1794.77	100	00	00	00	00
068	OTITIS MEDIA & URI AGE >=70 AND/OR C.C.	5.1	16	09	5.5	00	2280.06	1087.44	100	00	00	00	00
097	BRONCHITIS & ASTHMA AGE 18-69 W/O C.C.	5.1	17	09	5.6	00	2194.78	1129.67	88	00	00	00	11
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 18-69 W/O C.	4.9	18	09	5.4	00	1911.55	782.06	77	00	22	00	00
442	OTHER OR PROCEDURES FOR INJURIES AGE >=70 AND/OR C.C.	6.0	19	09	11.1	11	9778.49	3867.86	88	00	00	11	00
090	SIMPLE PNEUMONIA & PLEURISY AGE 18-69 W/O C.C.	5.2	20	08	8.2	00	4471.25	1404.67	75	00	12	00	12
294	DIABETES AGE >=36	6.8	21	08	4.7	00	1644.50	1212.97	100	00	00	00	00
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS AGE <70 W/O	3.9	22	07	6.2	00	2643.50	821.00	85	14	00	00	00
183	ESOPHAGITIS,GASTROENT& MISC DIGEST DIS AGE 18-69 W/O C	4.0	23	07	3.4	00	1340.11	629.57	100	00	00	00	00
022	HYPERTENSIVE ENCEPHALOPATHY	5.0	24	06	5.0	00	2303.13	991.78	100	00	00	00	00
039	LENS PROCEDURES	2.1	25	06	2.6	00	2738.28	673.12	66	00	00	00	33
080	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 18-69 W/O C	8.4	26	06	13.3	16	6523.85	2182.38	83	00	00	16	00
082	RESPIRATORY NEOPLASMS	6.5	27	06	7.5	00	2851.21	2298.62	66	00	00	33	00
099	RESPIRATORY SIGNS & SYMPTOMS AGE >=70 AND/OR C.C.	4.6	28	06	3.5	00	2376.12	960.72	83	16	00	00	00
121	CIRCULATORY DISORDERS WITH AMI & CV COMP DISCH ALIVE	10.3	29	06	13.3	00	7311.89	3259.40	100	00	00	00	00
024	SEIZURE & HEADACHE AGE >=70 AND/OR C.C.	5.0	30	05	12.0	00	4764.90	1459.73	80	20	00	00	00
025	SEIZURE & HEADACHE AGE 18-69 W/O C.C.	4.0	31	05	2.4	00	1356.68	948.85	80	20	00	00	00
069	OTITIS MEDIA & URI AGE 18-69 W/O C.C.	4.1	32	05	7.2	00	2629.16	733.57	100	00	00	00	00
122	CIRCULATORY DIS WITH AMI W/O CV COMP DISCH ALIVE	8.8	33	05	8.0	00	4400.68	1341.18	60	40	00	00	00
143	CHEST PAIN	3.5	34	05	6.4	20	2338.32	857.17	80	20	00	00	00
158	ANAL AND STOMAL PROCEDURES AGE >=70 AND/OR C.C.	3.9	35	05	4.8	00	2488.24	751.43	100	00	00	00	00
174	GI HEMORRHAGE AGE >=70 AND/OR C.C.	5.8	36	05	9.2	00	4232.26	1607.51	80	00	20	00	00
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >=70 AND/OR C.C.	4.3	37	05	9.0	00	3699.44	1652.62	80	20	00	00	00
254	FX,SPRNS,STRNS & DISL OF UPARM,LOWLEG EX FOOT,18-69 W/	4.0	38	05	5.4	00	2716.42	457.76	80	00	20	00	00
310	TRANSURETHRAL PROCEDURES AGE >=70 AND/OR C.C.	4.2	39	05	6.8	00	4391.94	1416.22	100	00	00	00	00
316	RENAL FAILURE	6.4	40	05	14.2	20	6399.17	2356.24	80	20	00	00	00
113	AMPUTATION FOR CIRC SYS DIS EXCEPT UPPER LIMB & TOE	16.8	41	04	16.0	00	7995.12	5031.52	75	00	25	00	00
116	PERMANENT CARDIAC PACEMAKER IMPLANT W/O AMI OR CHF	7.7	42	04	9.2	00	10968.05	5436.23	100	00	00	00	00
148	MAJOR SMALL & LARGE BOWEL PROCEDURES AGE >=70 AND/OR C	15.1	43	04	15.2	00	9232.76	6708.17	100	00	00	00	00
162	INGUINAL & FEMORAL HERNIA PROCEDURES AGE 18-69 W/O C.C	3.6	44	04	6.0	00	3242.32	550.12	100	00	00	00	00
172	DIGESTIVE MALIGNANCY AGE >=70 AND/OR C.C.	6.7	45	04	9.2	25	4029.56	2274.50	50	25	25	00	00
180	GI OBSTRUCTION AGE >=70 AND/OR C.C.	5.4	46	04	6.5	00	2323.05	1574.79	100	00	00	00	00
185	DENTAL & ORAL DIS EXC EXTRACTIONS & RESTORATIONS,AGE >	4.3	47	04	4.2	00	1703.46	984.16	100	00	00	00	00
197	TOTAL CHOLECYSTECTOMY W/O CDE AGE >=70 AND/OR C.C.	10.5	48	04	14.7	00	8145.77	3645.94	75	00	25	00	00
211	HIP & FEMUR PROCS EXCEPT MAJOR JOINT AGE 18-69 W/O C.C	12.7	49	04	8.5	00	5097.68	2940.41	75	00	25	00	00
236	FRACTURES OF HIP & PELVIS	8.9	50	04	12.2	25	3513.06	1322.14	75	25	00	00	00
	TOTAL CASES FOR HOSPITAL			741	8.6	03	4684.63	2105.49	82	03	05	06	01

NORTHWEST MISSISSIPPI REGIONAL MEDICAL CENTER
POST OFFICE BOX 1218 • CLARKSDALE, MS 38614 • (601) 627-3211

TO: MR. CLIFFORD JOHNSON, JR., FACHE
EXECUTIVE DIRECTOR

FROM: LELA KEYS, LSW Lela Key
DIRECTOR OF MEDICAL SOCIAL WORK

DATE: OCTOBER 14, 1988

RE: TRANSPORTATION SERVICES FOR THE ELDERLY

Coahoma County has five agencies that provides transportation to their elderly clients. Namely,

1. North Delta Planning and Development
2. Mississippians for the Community
3. Council on Aging - SLA Jones Center
4. Coahome Opportunities, Inc.
5. Knights of Columbus

The above agencies guidelines are so structured that they do not meet the needs of the elderly. Some few examples of their guidelines are listed below:

1. Liability insurance only covers their clients receiving services from their agencies.

2. Unable to transport out side of the service area.

3. Transportation services are not set up to handle unscheduled requests.

4. Transportation services only offered on certain days of the week.

These transportation services are not accessible to the elderly as these services do not meet their daily needs, such as, transportation to the doctor and hospital for out-patient services, transportation into Clarksdale to pay bills and to grocery shop, transportation to and from nursing homes to visit their elderly spouses or family members, and transportation from the hospital after discharge.

The Social Work Department here at the Medical Center has encountered many problems with their elderly patients relating to transportation. These problems may impede delay or prevent the delivery of services to the patient. An example of some of these problems encountered are:

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1. Elderly family members or spouses refuse admission of the patient to long-term care facilities outside the Coahoma County area, due to lack of transportation and/or funds to get to the facility to admit patient and later to visit regularly.

2. Non-emergency transport to long-term care of other acute care facilities may delay services to the patient when there is no transportation available.

An elderly resident may pay up to $15.00 per trip to Clarksdale and $25.00 or more for transportation out side the county.

The Social Work Department has received approximately one hundred-twenty requests for transportation this past year. Forty-five patients have been provided with funds through the American Cancer Society. Seventy-five patients have received assistance in arranging for transportation through innovative means.

The transportation problem is crucial to the elderly population's accessibility to services available.

We do hope that the information contained in this report will prove helpful.

Thank you for requesting our input.

LK:cb

Senator **Cochran**. Thank you very much, Clifford Johnson, for your testimony, very interesting, very informative, very distressing in many ways. We appreciate having the benefit of your observations and experience and knowledge. Let us now hear from Charles Shepherd. Charles has a statement that has been made available to us. He's president and chief executive officer of the H.C. Watkins Memorial Hospital in Quitman, Mississippi.

Mr. **Shepherd**. Senator, on behalf of the small rural hospitals in Mississippi, please accept our appreciation for your bringing this hearing to the State of Mississippi. We appreciate your ear. We appreciate your interest and the concern that you're showing through this subcommittee hearing.

I am Charles Shepherd, and I am the president of the H.C. Watkins Memorial Hospital in Quitman. The H.C. Watkins Hospital is owned by Clarke County, Mississippi, and is leased to a locally organized non-profit health care corporation for operation and management. Our small rural hospital is a 50-bed health care facility. Forty of those beds are General Acute and ten of those beds are licensed by the State of Mississippi as Personal Care beds. We were one of the first hospitals in the state, if not the first, to have an inhouse personal care unit. Of the forty beds remaining, ten are designated as swing beds. Our hospital is accredited by the Joint Commission on Accreditation of Health Care Organizations, and we are an active member of both the Mississippi Hospital Association and the American Hospital Association.

As you may know, we are situated in East Central Mississippi, which is a very predominately rural area of Mississippi. Our small hospital involves four neighboring counties as a service area. However, our primary population service base is Clarke County, some 16,900 people, many of whom are either Medicare or Medicaid recipients. There are others which are neither Medicare or Medicaid, but rather fall within an economic bracket which does not provide them the means to pay for hospital care.

Today, Senator, rural health care, more especially hospital care, and the elderly health care which is provided by our small rural hospitals stands at a crossroads. The small rural hospital of Mississippi, and even of America, is not sure as to which of those roads it should take. It's a decision that we constantly make based not upon fact but upon conjecture. We believe as small rural hospital administrators that it's time to resolve the dilemma that's surrounding America's small rural hospitals, which for many years have been the defenders and the primary providers of elderly health care. And it is our hope, Senator, that your hearing is a step in that direction.

Prior to the inception of the Prospective Payment System in 1983, our particular hospital, like most small rural hospitals, was able to provide a satisfactory standard of hospital care to a growing, to an aging population. We did not hoard large sums of money. We were not guilty of making excessive patient charges nor were we guilty of flagrantly abusing the Medicare program.

Nonetheless, with the inception of the Prospective Payment System, Senator, we were thrust into a most untenable, almost stepchild like position. An analogy of our present position that I often use is that of the pesky fire ant which literally covers the forest and the meadows of Mississippi. We have come to the conclusion that we've been stomped upon, driven over, turned over, rained upon, and yet miraculously, the small rural hospital is still around, much to the joy of our elderly population.

I'd like to give you the basis for my contention. In the four years prior to PPS, our hospital was able to maintain revenues and occupancy levels that allowed us to operate on a slightly better than break-even basis. Because of our hospital's dependency on Medicare and Medicaid, the changes bought about by the introduction of PPS caused revenues to begin to fall along with declining occupancy levels. Although we were able to reduce costs from our 1982 level, it was impossible to avoid operating losses, which have averaged in excess of $175,000 per year. The cumulative losses during those first five years of PPS alone have been roughly $900,000. We simply cannot survive at that pace. Census levels have dropped at our hospital from approximately 70 percent to an average of about 50 percent since the inception of PPS, and there is simply no industry of any kind that can survive with an operating capacity of only 50 percent.

We have reacted as positively and as creatively as we are capable of reacting, Senator. Costs have been cut below the 1982 level by an average of approximately $300,000 per year. We became involved in the Swing Bed program and the Personal Care program, which have resulted in slight revenue increases and smaller operating losses. However, operating losses continue and our assets are being rapidly consumed. If we can use 1982 as the benchmark when compared to the average of the succeeding five years, revenues are down almost $800,000 per year or approximately $4,000,000 for that period. Even though we were able to cut operating costs and even some uncompensated care costs by $500,000 a year, the results have still been disastrous.

In an effort to respond to an adverse health care environment, our hospital has aggressively pursued new services and new programs in an effort to strengthen the financial base of our hospital while fulfilling a perceived community need. The Swing Bed Program has been of a substantial patient value, especially for our elderly population in Clarke County, but of limited financial value with a per diem rate of only $86.76 per day. The ten beds of Private Personal Care unit has met a community need and has been more satisfactorily rewarding to the hospital than has been some of the other elderly service programs.

A Respite Care Program has been developed, and it's beginning to reflect some progress as an elderly service program. Presently, the Governing Board and Administration of our hospital is in the process of developing an Elderly Housing Project which, according to a Mississippi State University Feasibility Study, has a substantial service potential. We have introduced and implemented industrial health programs, health fairs. We have carried out a very intensified physician recruitment program.

The hospital that I represent recognizes that with the Medicare admission rate of 59 percent, the far greater majority being our elderly people, the private sector must become a target area. But we cannot deny the fact that the elderly population clearly prefers to receive hospital care within the community of their residence.

Therefore, the hospital can anticipate a continuing influx of elderly patients. This factor, Senator, simply has to be addressed by both our hospital as well as the Congress of the United States. Please allow me to take just a moment to reflect upon the Prospective Payment System.

If the small rural hospitals of Mississippi are to survive and if we are to continue to provide services to our elderly people, the iniquities, the discriminatory practice of the Prospective Payment System simply must be resolved. There must evolve a new attitude or more positive attitude toward rural health care both in Mississippi and on the national level. The Professional Review Organizations must credit small rural hospitals and the rural physician for their capability of performance rather than discouraging utilization of these cost effective facilities.

Small rural hospitals must be freed from burdensome IRS regulations which make physician recruitment even more difficult. The Hill-Burton Charity care requirements must be relaxed in this period of increasing Medicare contractual adjustments. Recognition must be afforded to the fact that health manpower costs are as great for a small rural facility as for a neighboring urban facility. The Congress must understand that technological costs for specific service areas are no less in rural than urban facilities.

Statistical data recognizes that the less expensive hospital care is being provided in the small hospital and the closure of these facilities will not lessen the demand for the service, but rather act to increase the cost for both the patient and for the government. An awareness must develop that the professional service of a rural physician is just as effective as that of his urban counterparts and he should be so equally compensated.

The Health Care Financing Administration should be required to actively seek the input of rural health care providers before arbitrarily changing any component within the reimbursement system. Furthermore, the Congress should act to assure that the Health Care Financing Administration and even the Office of Management and Budget carry out in a prudent manner those statutes which are enacted by Congress for the positive financial benefit of rural health care providers. Gaming in the system which we have experienced simply cannot be tolerated in the future. Costly empty beds in a small rural hospital could be effectively utilized as nursing home beds so as to alleviate the dearth of nursing home beds in Mississippi and in our Nation.

The inflationary spiral, Senator, of doing business is no less in the hospital as it is in any other business, yet hospital reimbursement, as you have heard from these other gentlemen, lags much too far behind. Market basket adjustment is not the only monetary adjustment that needs to be made within PPS.

Attached to my written report and submitted to your office is a computer printout from the Mississippi Foundation of Medical Care which clearly delineates the inequitable payment system of the Prospective Payment Program, even among hospitals in your state. When any inequitable payment system is combined with an unbearable 442 million dollars of uncompensated care in the State of Mississippi alone, it is little wonder that all hospitals both large and small cry out for relief. It is also little wonder in the recent

Touche Roche Survey indicated that 48 percent of the respondent executives nationwide felt that their hospital, large or small, was vulnerable to failure. The American Hospital Association reported that in the last two years 150 community hospitals have closed including 79 last year alone.

Congress cannot continue to slash funding for the Medicare program and at the same time expect the continued survival of small rural hospitals and the elderly services they provide. The health care economic system simply does not work that way. From our perception, hospitals have paid more than a fair share toward balancing the federal budget. It is time for the pendulum to swing back toward center—a center, Senator, that cares for the needs of our elderly citizens. A center that recognizes that health services are vital services and therefore they, too, must be protected. Congress must search for ways, as you are doing today in Mississippi, to ease the economic problems of rural hospitals so that the elderly services they provide will remain the mainstay of America's health care system.

Please, once again, accept my appreciation on behalf of myself and our small rural hospitals for your coming to this state today.

[The prepared statement of Mr. Shepherd, with an attachment, follow:]

CHARLES W. SHEPHERD
PRESIDENT & CHIEF EXECUTIVE OFFICER
H. C. WATKINS MEMORIAL HOSPITAL

Testimony Before Senate Subcommittee on Rural Health Care
October 20, 1988
Tupelo, Mississippi

My name is Charles W. Shepherd. I am the President and Chief Executive Officer of the H. C. Watkins Memorial Hospital in Quitman, Mississippi. I am surely appreciative of the opportunity to appear before this subcommittee and express my views on rural health care.

H. C. Watkins Memorial Hospital is owned by Clarke County, Mississippi, and is leased to a locally organized non-profit health care corporation, the H. C. Watkins Memorial Hospital, Inc., for operation and management. The hospital is a 50 bed health care facility. Of the 50 beds, 40 are designated as General Acute Surgical and 10 are licensed by the State of Mississippi as Personal Care beds. Of the 40, 10 are designated as Swing Beds. The hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations and is a member of both the Mississippi Hospital Association and the American Hospital Association. We are situated in East Central Mississippi, which is a predominately rural area of our state. Although our service area encompasses the fringe area of four neighboring counties, Clarke County, Mississippi proper has a population base of approximately 16,900 - many of whom are either Medicare or Medicaid recipients. Others are neither Medicare nor Medicaid, but fall within an economic bracket which does not provide them the means to pay for hospital care.

Today, gentlemen, rural health care, more especially hospital care, stands at a crossroads. The small rural hospital of Mississippi, and even of America, has been arbitrarily placed in the position of not knowing which road it should take. It is a decision based merely upon conjecture. It's time to resolve the atrocious dilemma surrounding America's small rural hospitals. Hopefully, this hearing is a step forward in that direction.

Prior to inception of the Prospective Payment System on October 1, 1983, our small rural hospital, like most, was able to provide a satisfactory standard of hospital care to a growing, aging population. We did not hoard large sums of money, we were not guilty of making excessive patient charges, nor were we guilty of flagrantly abusing the Medicare program. Nonetheless, with the inception of the Prospective Payment System, we were thrust into a most untenable, almost stepchild like, position. An analogy of our present position is that of the pesky fire ant which literally covers the forest and meadows of Mississippi. We have been stomped upon, driven over, turned over, and rained upon, yet, miraculously, we are still around. Those we so faithfully serve rejoice in that fact.

Consider, if you will, the basis for my contention:

In the four years prior to PPS, we were able to maintain revenues and occupancy levels that allowed us to operate on a slightly better than break-even basis. Because of the hospital's significant dependency on Medicare and Medicaid patients, the changes brought about by the introduction of PPS caused revenues to begin to fall, along with declining occupancy levels. Although we were able to reduce cost from the 1982 levels substantially, it was impossible to avoid operating losses, which have averaged in excess of $175,000 per year. The cumulative losses during those first five years of PPS were roughly $900,000. We obviously can't survive much longer at that pace. Census levels have dropped at the H. C. Watkins Memorial Hospital from approximately 70% to an average of only about 50% since PPS. What industry can continue to operate at 50% of capacity? (Reference: Exhibits I and II)

We have reacted as positively and creatively as we are capable of reacting. Costs have been cut below the 1982 level by an average of approximately $300,000 per year. We became involved in both the Swing Bed program and Personal Care Bed program in 1986, which resulted in slight revenue increases and smaller operating losses. However, operating losses continue and assets are being consumed. If 1982 can be used as a benchmark, when compared to the average of the succeeding 5 years, revenues are down almost $800,000 per year or approximately $4,000,000 for that period. Even though we were able to cut operating costs and uncompensated care costs by $500,000 per year, the result was still disastrous.

In an effort to respond to an adverse health care environment, especially for small rural hospitals, the H. C. Watkins Memorial Hospital has aggressively pursued new services and new programs in an effort to strengthen the financial base of the hospital while fulfilling a perceived community service need. The Swing Bed Program has been of a substantial patient value, yet of limited financial benefit at a per diem rate of eighty-six dollars and seventy-six ($86.76) per day. The ten-bed, private-pay Personal Care Unit has met a community need and has been the more financially satisfactory of the two programs. A Respite Care Program has been developed and is beginning to reflect some progress as a service program. Presently, the Governing Board and the Administration of the hospital is in the process of developing an Elderly Housing Project which, according to a Mississippi State University Feasibility Study, has a substantial service potential. In addition, the hospital has implemented an Industrial Health Program aimed at developing a greater private pay base for the hospital. Health Fairs, an aggressive marketing program, and an intensified Physician Recruitment Program have been carried forward by the hospital. The H. C. Watkins Hospital recognizes that with a Medicare admission rate of 59%, the private sector must become a target area. Even so, the hospital cannot deny the fact that the elderly population clearly prefers to receive hospital care within the county of residence; therefore, the hospital can anticipate a continuing influx of Medicare patients. This factor must be addressed by both the hospital and the Congress of the United States. It is at this point that we must address the Prospective Payment System and its effect upon small rural hospitals.

If the small rural hospitals of Mississippi are to survive, the inequities, the discriminatory practice of the Prospective Payment System must be resolved. There must evolve a new attitude, a more positive attitude, toward rural health care, both in Mississippi and on the national level. The Professional Review Organizations must credit small rural hospitals, and the rural physician, for their capability of performance, rather than discouraging utilization of these cost effective facilities. Small rural hospitals must be freed from burdensome IRS regulations which make physician recruitment even more difficult. The Hill-Burton Charity care requirement must be relaxed in this period of increasing Medicare contractual adjustments. Recognition must be afforded to the fact that health manpower costs are as great for a small rural facility as for a neighboring urban facility. The Congress must understand that technological costs for specific service areas are no less in rural than urban facilities. Statistical data recognizes that the less expensive hospital care is being provided in the small hospital and the closure of these facilities will not lessen the demand for the service, but rather act to increase the cost for both the patient and the government. An awareness must develop that the professional service of a rural physician is just as effective as that of his urban counterparts and he should be so equally compensated. The Health Care Financing Administration should be required to actively seek the input of rural health care providers before arbitrarily changing any component within the reimbursement system. Furthermore, the Congress must act so as to assure that Health Care Financing Administration, and the Office of Management and Budget, carry out in a prudent manner those statutes enacted by Congress for the positive financial benefit of rural health care providers. Gaming in the system can no longer be tolerated. Costly empty beds in a small rural hospital could be effectively utilized as Nursing Home beds so as to alleviate the death of nursing home beds in Mississippi and in our nation.

The inflationary spiral of doing business is no less in the hospital as in any other business, yet hospital reimbursement under PPS lags much too far behind. Market basket adjustment is not the only monetary adjustment that should be made within the PPS. Attached to this report is a computer printout from the Mississippi Foundation for Medical Care (MFMC) which clearly delineates the inequitable payment system of the Prospective Payment Program, even among Mississippi hospitals. I urge your careful perusal of that exhibit (marked as Exhibit III). When any inequitable payment system is combined with an unbearable four hundred and forty-two million dollars ($442,000,000) of uncompensated care, in Mississippi alone (MHA-1987 Uncompensated Care Survey), one can easily understand why hospitals, both large and small, cry out for relief. It is little wonder, as a recent Touche Ross Survey indicated, that forty-eight (48) percent of the respondent executives nation-wide felt that their hospital was vulnerable to failure. The American Hospital Association has reported that in the last two years one hundred fifty (150) community hospitals have closed, including seventy-nine (79) in 1987, a record high. This loss constitutes more than the mere loss of health care facilities, as it also means the loss of jobs and economic benefits for the respective communities.

Congress cannot continue to slash funding for the Medicare program and at the same time expect the continued survival of small rural hospitals. The health care economic system simply does not work that way. Hospitals, from our perception, have paid a more than fair amount toward the balancing of the

Federal Budget. It is time for the pendulum to swing back toward center....a center that cares for the needs of our elderly .....a center that recognizes that health care services are vital services and must, therefore, be protected. Congress must search for ways, as you are doing today, to ease the economic problems of rural hospitals so that the services they provide will remain the mainstay of America's Health Care System.

Thank you for your attention, your concern, and the opportunity to be a part of these proceedings.

EXHIBIT I

H. C. WATKINS MEMORIAL HOSPITAL, INC.

ACUTE CARE

Year	Total Admissions	Total Patient Days	Total Medicare Admissions	Total Medicare Days	Medicare Out-Patients	
* 1979	1944	16,226	956	10,076	973	
1980	1746	14,236	861	8,540	875	
1981	1749	13,688	878	8,443	945	
1982	1758	13,496	949	8,831	851	
1983	1609	12,077	927	8,146	912	
1984	1501	9,296	841	6,073	1082	
1985	1317	6,803	758	4,423	1235	
** 1986	1234	6,860	717	4,510	1843	
1987	1212	7,292	713	4,312	2116	
1988	626	3,459	365	2,096	877	(January thru June)

SWINGBED

Year	Admissions	Patient Days	
1985	167	2,130	
1986	160	2,401	
1987	144	2,114	
1988	82	1,198	(January thru June)

* 50 Bed Capacity
** 40 Bed Capacity

EXHIBIT II

Excerpt from:

1987
ANNUAL REPORT ON
HOSPITALS
LICENSED BY

MISSISSIPPI STATE DEPARTMENT OF HEALTH
P.O. Box 1700
Jackson, Mississippi 39216

PUBLISHED MAY, 1988
Health Facilities Licensure and Certification
Mendal Kemp, Chief

and

Public Health Statistics
Nita Gunter, Director

TABLE XI.-A

AVERAGE LENGTH OF STAY, AVERAGE DAILY CENSUS, OCCUPANCY RATE BY ACUTE CARE CATEGORY FOR MISSISSIPPI HOSPITALS FOR 1987

HOSPITAL	LICENSED BEDS	AVERAGE LENGTH OF STAY	AVERAGE DAILY CENSUS	OCCUPANCY RATE
ABERDEEN MONROE COUNTY HOSPITAL	84	5.08	14.58	17.36
BALDWYN SATELLITE HOSPITAL	49	3.66	10.31	21.04
BAPTIST MEMORIAL HOSPITAL	121	5.60	40.63	33.58
BEACHAM MEMORIAL HOSPITAL	37	5.69	17.04	46.06
BILOXI REGIONAL MEDICAL CENTER	153	5.84	86.13	56.30
BOLIVAR COUNTY HOSPITAL	165	6.32	82.83	50.20
CHOCTAW COUNTY HOSPITAL	28	4.95	13.84	49.42
CLAIBORNE COUNTY HOSPITAL	32	4.05	8.02	25.07
CLAY COUNTY MEDICAL CENTER	60	4.59	28.59	47.64
COLUMBUS HOSPITAL INC	58	5.90	40.28	69.46
COMMUNITY HOSPITAL OF CALHOUN CO	49	3.87	5.50	11.23
COVINGTON COUNTY HOSPITAL	82	5.29	20.16	24.59
DELTA MEDICAL CENTER	231	6.95	100.68	43.58
DISTRICT TWO COMMUNITY HOSPITAL	29	7.59	9.62	33.16
DOCTORS HOSPITAL	127	5.63	23.66	18.63
ELLISVILLE MUNICIPAL HOSPITAL	17	5.67	3.17	18.63
F G RILEY MEMORIAL HOSPITAL	168	6.36	111.81	66.55
FIELD MEMORIAL COMMUNITY HOSPITAL	66	4.09	21.10	31.96
FORREST GENERAL HOSPITAL	429	5.81	266.93	62.22
FRANKLIN COUNTY MEMORIAL HOSPITAL	53	4.78	10.02	18.91
GARDEN PARK COMMUNITY HOSPITAL	120	6.45	50.52	42.10
GEORGE COUNTY HOSPITAL	53	4.78	17.96	33.88

TABLE XI.-A

AVERAGE LENGTH OF STAY, AVERAGE DAILY CENSUS AND OCCUPANCY RATE BY ACUTE CARE CATEGORY FOR MISSISSIPPI HOSPITALS IN 1987

HOSPITAL	LICENSED BEDS	AVERAGE LENGTH OF STAY	AVERAGE DAILY CENSUS	OCCUPANCY RATE
GILMORE MEMORIAL HOSPITAL	95	4.51	45.59	47.99
GOLDEN TRIANGLE REGIONAL MED CTR	248	5.35	112.23	45.25
GREENE COUNTY HOSPITAL	14	3.56	3.03	21.66
GREENWOOD LEFLORE HOSPITAL	260	5.48	123.89	47.65
GRENADA COUNTY HOSPITAL	156	4.85	60.96	39.08
GULF COAST COMMUNITY HOSPITAL	144	6.11	77.92	54.11
H C WATKINS MEMORIAL HOSPITAL	40	5.94	19.50	48.74
HANCOCK GENERAL HOSPITAL	60	4.71	34.85	58.08
HARDY WILSON MEMORIAL HOSPITAL	49	4.71	21.13	43.13
HILLCREST HOSPITAL	30	3.83	9.53	31.75
HINDS GENERAL HOSPITAL	474	6.75	218.79	46.16
HOUSTON COMMUNITY HOSPITAL	84	4.48	22.97	27.35
HUMANA HOSPITAL - NATCHEZ	85	5.37	25.08	29.51
HUMPHREYS COUNTY MEMORIAL HOSPITAL	25	4.48	9.03	36.11
ITAWAMBA COUNTY HOSPITAL	49	7.41	14.81	30.23
JASPER GENERAL HOSPITAL	49	6.27	6.92	14.12
JEFF ANDERSON REGIONAL MED CNTR	250	5.96	139.42	55.77
JEFFERSON COUNTY HOSPITAL	30	4.78	15.13	50.45
JEFFERSON DAVIS COUNTY HOSPITAL	41	4.53	7.04	17.16
JEFFERSON DAVIS MEMORIAL HOSPITAL	205	5.10	92.68	45.21
JONES COUNTY COMMUNITY HOSPITAL	258	5.73	146.70	56.86
KILMICHAEL HOSPITAL	19	4.93	11.12	58.54

TABLE XI.-A

AVERAGE LENGTH OF STAY, AVERAGE DAILY CENSUS AND OCCUPANCY RATE BY ACUTE CARE CATEGORY FOR MISSISSIPPI HOSPITALS IN 1987

HOSPITAL	LICENSED BEDS	AVERAGE LENGTH OF STAY	AVERAGE DAILY CENSUS	OCCUPANCY RATE
KING'S DAUGHTERS HOSP -BROOKHAVEN	135	6.14	54.05	40.04
KING'S DAUGHTERS HOSP -GREENVILLE	137	5.35	55.56	40.56
KING'S DAUGHTERS HOSP -YAZOO CITY	88	5.12	29.36	33.36
KUHN MEMORIAL STATE HOSPITAL	84	4.97	18.96	22.58
LAIRD HOSPITAL	45	4.76	27.09	60.21
LAWRENCE COUNTY HOSPITAL	53	5.60	22.32	42.11
LEAKE COUNTY MEMORIAL HOSPITAL	35	8.48	11.88	33.95
LUCIUS OLEN CROSBY MEMORIAL HOSP	95	4.58	43.47	45.76
LUMBERTON CITIZENS HOSPITAL	23	4.71	7.01	30.46
MADISON GENERAL HOSPITAL	67	4.46	21.45	32.02
MAGEE GENERAL HOSPITAL	64	6.56	35.02	79.58
MAGNOLIA HOSPITAL	178	5.72	73.26	41.16
MARION COUNTY GENERAL HOSPITAL	90	4.98	36.03	40.04
MARSHALL COUNTY HOSPITAL	40	5.03	14.06	35.15
MATTY HERSEE HOSPITAL	66	4.60	28.48	43.16
MEMORIAL HOSPITAL AT GULFPORT	263	5.58	172.54	65.61
MERCY REGIONAL MEDICAL CENTER	157	6.29	69.73	44.42
MERIDIAN REGIONAL HOSPITAL	94	9.08	60.53	64.39
METHODIST HOSPITAL OF MIDDLE MISS	84	5.04	37.58	44.74
METHODIST HOSPITAL OF STONE COUNTY	49	4.54	15.86	32.37
METHODIST HOSPITAL - HATTIESBURG	201	6.18	137.69	68.50
MISSISSIPPI BAPTIST MEDICAL CENTER	566	6.73	415.19	73.35

TABLE XI.-A

AVERAGE LENGTH OF STAY, AVERAGE DAILY CENSUS AND OCCUPANCY RATE
BY ACUTE CARE CATEGORY
FOR MISSISSIPPI HOSPITALS IN 1987

HOSPITAL	LICENSED BEDS	AVERAGE LENGTH OF STAY	AVERAGE DAILY CENSUS	OCCUPANCY RATE
MONTFORT JONES MEMORIAL HOSPITAL	78	4.47	28.84	36.97
ESHOBA COUNTY GENERAL HOSPITAL	82	4.10	23.25	28.36
NORTH MISSISSIPPI MEDICAL CENTER	554	6.52	404.01	72.93
ORTH PANOLA REGIONAL HOSPITAL	54	4.83	19.39	35.90
NORTH SUNFLOWER COUNTY HOSPITAL	82	7.07	20.79	25.35
ORTHWEST MISS REGIONAL MED CTR	194	5.55	127.42	65.68
OXUBEE GENERAL HOSPITAL	49	5.58	18.76	38.28
OCEAN SPRINGS HOSPITAL	124	5.02	59.30	47.83
KOLONA COMMUNITY HOSPITAL	17	5.07	5.46	32.14
OKTIBBEHA COUNTY HOSPITAL	96	4.36	46.27	48.20
ORD-LAFAYETTE COUNTY HOSPITAL	145	5.47	98.87	68.19
EARL RIVER COUNTY HOSPITAL	30	4.62	10.28	34.27
PERRY COUNTY GENERAL HOSPITAL	44	6.50	8.47	19.25
ONTOTOC COMMUNITY HOSPITAL & ECF	59	4.85	18.36	31.12
QUITMAN COUNTY HOSPITAL	36	5.33	24.90	69.17
ANKIN GENERAL HOSPITAL	90	5.86	43.80	48.67
ILEY-KEMPER COMMUNITY HOSPITAL	35	5.79	6.37	18.21
RIVER OAKS HOSPITAL INC	100	4.63	48.66	48.66
USH FOUNDATION HOSPITAL	205	5.82	136.51	66.59
RUSH HOSPITAL - NEWTON	49	5.40	12.14	24.78
E LACKEY MEMORIAL HOSPITAL	44	4.33	9.62	21.87
SENATOBIA COMMUNITY HOSPITAL	76	3.93	18.78	24.72
SHARKEY-ISSAQUENA COMMUNITY HOSP	29	3.90	10.38	35.81

TABLE XI.-A

AVERAGE LENGTH OF STAY, AVERAGE DAILY CENSUS AND OCCUPANCY RATE BY ACUTE CARE CATEGORY FOR MISSISSIPPI HOSPITALS IN 1987

HOSPITAL	LICENSED BEDS	AVERAGE LENGTH OF STAY	AVERAGE DAILY CENSUS	OCCUPANCY RATE
WEST SCOTT BAPTIST HOSPITAL	30	4.31	11.25	37.51
WHITFIELD MEDICAL SURGICAL HOSP	43	11.61	17.68	41.13
WINSTON COUNTY COMMUNITY HOSPITAL	65	5.61	35.19	54.15
WOMAN'S HOSPITAL	111	4.52	43.47	39.16
YALOBUSHA GENERAL HOSPITAL	38	5.93	13.68	36.02

H. C. WATKINS MEMORIAL HOSPITAL, INC.

ACUTE CARE

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* 50 Bed Capacity
** 40 Bed Capacity

TABLE XI.-A

AVERAGE LENGTH OF STAY, AVERAGE DAILY CENSUS AND OCCUPANCY RATE BY ACUTE CARE CATEGORY FOR MISSISSIPPI HOSPITALS IN 1987

HOSPITAL	LICENSED BEDS	AVERAGE LENGTH OF STAY	AVERAGE DAILY CENSUS	OCCUPANCY RATE
SHELBY COMMUNITY HOSPITAL	23	3.93	8.69	37.78
SIMPSON GENERAL HOSPITAL	49	5.80	19.39	39.58
SINGING RIVER HOSPITAL	386	6.07	228.69	59.25
SMITH COUNTY GENERAL HOSPITAL	29	5.72	9.56	32.97
SOUTH MISSISSIPPI STATE HOSPITAL	95	4.10	29.10	30.63
SOUTH PANOLA COMMUNITY HOSPITAL	70	4.33	22.71	32.44
SOUTH SUNFLOWER COUNTY HOSPITAL	69	4.68	36.62	53.08
SOUTH WASHINGTON COUNTY HOSPITAL	40	5.95	12.51	31.28
SOUTHWEST MISSISSIPPI MED CTR	160	5.65	118.01	73.76
ST DOMINIC JACKSON MEMORIAL HOSP	355	6.55	223.77	63.03
TALLAHATCHIE GENERAL HOSPITAL	25	4.13	7.51	30.04
THAGGARD HOSPITAL	22	4.70	9.64	43.81
TIPPAH COUNTY HOSPITAL	99	7.36	32.56	32.89
TISHOMINGO COUNTY HOSPITAL	99	5.66	28.72	29.01
TUNICA COUNTY HOSPITAL	22	3.46	4.65	21.15
TYLER HOLMES MEMORIAL HOSPITAL	49	5.11	23.59	48.15
UNION COUNTY GENERAL HOSPITAL	153	4.69	84.72	55.38
UNIVERSITY MEDICAL CENTER	531	6.59	397.87	74.93
VICKSBURG MEDICAL CENTER	144	6.03	72.86	50.60
WALTHALL COUNTY GENERAL HOSPITAL	49	5.00	24.81	50.64
WAYNE GENERAL HOSPITAL	80	4.70	40.42	50.53
WEBSTER GENERAL HOSPITAL	76	4.83	27.91	36.73

00[illegible] . WATKINS [illegible] HOSP.   MISSISSIPPI FOUN[illegible] 'ON FOR MEDICAL CARE   RUN DATE [illegible]5/88

HOSPITAL DRG PROFILE

01/01/88 THRU 03/31/88

DRG	TITLE	GEOM ALOS	RNK	CASES	ALOS	%DAY OUTL	AVG CHARGES	AVG REIMB	% DISCHARGED TO HOM	TRANS	LTC	EXP	OTH
089	SIMPLE PNEUMONIA & PLEURISY AGE >=70 AND/OR C.C.	7.5	01	12	7.5	00	3226.87	2260.44	66	08	08	08	08
096	BRONCHITIS & ASTHMA AGE >=70 AND/OR C.C.	6.0	02	10	5.1	00	2101.65	1532.08	90	00	00	00	10
140	ANGINA PECTORIS	4.6	03	09	4.8	00	1732.12	1012.00	77	11	11	00	00
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 70+ &/OR C.	6.0	04	09	3.7	00	2157.27	1475.54	44	11	11	33	00
127	HEART FAILURE & SHOCK	6.7	05	08	4.5	00	2100.28	1672.82	75	12	00	00	12
182	ESOPHAGITIS,GASTROENT& MISC DIGEST DIS AGE 70+ &/OR C.	4.7	06	08	6.5	00	2536.26	961.60	62	12	12	00	12
243	MEDICAL BACK PROBLEMS	6.2	07	08	7.6	00	2569.36	970.62	100	00	00	00	00
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS AGE 70+ &/OR	4.9	08	07	5.0	00	3094.26	1155.06	85	00	14	00	00
090	SIMPLE PNEUMONIA & PLEURISY AGE 18-69 W/O C.C.	6.2	09	06	8.6	00	3794.66	1299.11	100	00	00	00	00
014	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	8.5	10	05	8.6	00	3030.55	2122.11	60	00	40	00	00
015	TRANSIENT ISCHEMIC ATTACKS AND PRECEREBRAL OCCLUSIONS	4.6	11	04	5.0	00	2009.22	895.00	75	00	25	00	00
097	BRONCHITIS & ASTHMA AGE 18-69 W/O C.C.	5.1	12	04	5.0	00	2454.80	1202.82	100	00	00	00	00
174	GI HEMORRHAGE AGE >=70 AND/OR C.C.	5.8	13	04	7.0	00	3336.56	1858.78	75	00	25	00	00
183	ESOPHAGITIS,GASTROENT& MISC DIGEST DIS AGE 18-69 W/O C	4.0	14	04	5.0	00	1916.25	676.32	100	00	00	00	00
209	MAJOR JOINT AND LIMB REATTACHMENT PROCEDURES	14.4	15	04	11.0	00	6300.90	4808.15	00	00	100	00	00
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 70+ &/OR	4.6	16	04	4.5	00	1562.37	614.60	50	25	00	25	00
294	DIABETES AGE >=36	6.8	17	04	6.7	00	2163.00	1009.24	75	00	25	00	00
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 18-69 W/O C	4.9	18	04	6.5	00	2136.93	923.91	100	00	00	00	00
068	OTITIS MEDIA & URI AGE >=70 AND/OR C.C.	5.1	19	03	4.6	00	1284.50	947.88	66	00	33	00	00
082	RESPIRATORY NEOPLASMS	6.5	20	03	6.0	00	2092.16	2033.88	100	00	00	00	00
088	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	6.6	21	03	5.0	00	1941.28	1774.98	66	00	00	33	00
099	RESPIRATORY SIGNS & SYMPTOMS AGE >=70 AND/OR C.C.	4.6	22	03	4.3	00	2937.21	696.07	00	100	00	00	00
128	DEEP VEIN THROMBOPHLEBITIS	8.6	23	03	7.0	00	2198.73	1399.85	100	00	00	00	00
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS AGE <70 W/O	3.9	24	03	4.3	00	1834.28	864.71	100	00	00	00	00
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >=70 AND/OR C.C.	4.3	25	03	2.3	00	980.03	1485.71	33	00	33	33	00
012	DEGENERATIVE NERVOUS SYSTEM DISORDERS	7.8	26	02	2.5	00	1003.65	1652.46	100	00	00	00	00
121	CIRCULATORY DISORDERS WITH AMI & CV COMP DISCH ALIVE	10.3	27	02	1.5	00	1306.25	1513.05	50	50	00	00	00
143	CHEST PAIN	3.5	28	02	3.0	00	1870.55	875.09	50	00	00	50	00
150	PERITONEAL ADHESIOLYSIS AGE >=70 AND/OR C.C.	12.6	29	02	15.5	00	12967.57	4939.38	50	00	50	00	00
161	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >=70 AND/OR C	4.4	30	02	4.0	00	2270.25	1033.99	100	00	00	00	00
180	GI OBSTRUCTION AGE >=70 AND/OR C.C.	5.4	31	02	6.5	00	2235.12	1630.86	100	00	00	00	00
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	6.4	32	02	7.0	00	2832.62	1862.56	50	00	50	00	00
210	HIP & FEMUR PROCS EXCEPT MAJOR JOINT AGE 70+ &/OR C.C.	14.7	33	02	8.0	00	6288.67	3877.88	00	00	100	00	00
244	BONE DISEASES & SEPTIC ARTHROPATHY AGE >=70 AND/OR C.C	6.1	34	02	7.5	00	2297.75	970.68	100	00	00	00	00
320	KIDNEY & URINARY TRACT INFECTIONS AGE >=70 AND/OR C.C.	6.5	35	02	3.5	00	1543.05	1854.49	50	00	50	00	00
321	KIDNEY & URINARY TRACT INFECTIONS AGE 18-69 W/O C.C.	5.1	36	02	5.5	00	1635.40	968.25	50	00	50	00	00
364	D&C,CONIZATION EXCEPT FOR MALIGNANCY	2.2	37	02	1.5	00	1407.50	610.33	100	00	00	00	00
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	2.6	38	02	4.0	00	1198.87	1273.70	50	00	00	00	50
468	UNRELATED OR PROC	11.5	39	02	19.5	00	7756.87	4846.29	50	00	50	00	00
005	EXTRACRANIAL VASCULAR PROCEDURES	7.9	40	01	5.0	00	4022.30	2658.29	100	00	00	00	00
022	HYPERTENSIVE ENCEPHALOPATHY	5.0	41	01	15.0	00	6036.35	933.35	00	00	100	00	00
023	NONTRAUMATIC STUPOR & COMA	5.2	42	01	4.0	00	1478.00	1403.08	100	00	00	00	00
032	CONCUSSION AGE 18-69 W/O C.C.	2.8	43	01	3.0	00	1116.00	301.82	100	00	00	00	00
065	DYSEQUILIBRIUM	3.8	44	01	8.0	00	2469.00	406.84	100	00	00	00	00
079	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 70+ &/OR C.	9.6	45	01	8.0	00	3821.25	4219.95	100	00	00	00	00
080	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 18-69 W/O C	8.4	46	01	10.0	00	4119.25	2762.37	100	00	00	00	00
083	MAJOR CHEST TRAUMA AGE >=70 AND/OR C.C.	6.6	47	01	6.0	00	1895.25	2008.06	100	00	00	00	00
101	OTHER RESPIRATORY DIAGNOSES AGE >=70 AND/OR C.C.	6.0	48	01	4.0	00	2348.90	1452.21	100	00	00	00	00
116	PERMANENT CARDIAC PACEMAKER IMPLANT W/O AMI OR CHF	7.7	49	01	9.0	00	10620.05	5097.41	100	00	00	00	00
123	CIRCULATORY DISORDERS WITH AMI, EXPIRED	3.0	50	01	1.0	00	1145.75	2311.79	00	00	00	100	00
TOTAL CASES FOR HOSPITAL				206	6.6	00	2943.77	1849.22	71	02	19	04	01

EXHIBIT III

BEDTYPE DRG PROFILE

01/01/88 THRU 03/31/88

DRG	TITLE	GEOM ALOS	RNK	CASES	ALOS	%DAY OUTL	AVG CHARGES	AVG REIMB	% DISCHARGED TO HOM	TRANS	LTC	EXP	OTH
089	SIMPLE PNEUMONIA & PLEURISY AGE >=70 AND/OR C.C.	7.5	01	454	7.7	01	3876.10	2279.84	57	07	17	11	05
127	HEART FAILURE & SHOCK	6.7	02	445	6.7	00	3184.68	1779.27	68	06	09	07	07
096	BRONCHITIS & ASTHMA AGE >=70 AND/OR C.C.	6.0	03	374	6.5	01	3353.42	1678.35	84	04	05	01	04
182	ESOPHAGITIS,GASTROENT& MISC DIGEST DIS AGE 70+ &/OR C.	4.7	04	277	4.5	00	1844.98	1098.58	82	05	07	01	03
140	ANGINA PECTORIS	4.6	05	230	4.3	00	1984.54	981.40	86	05	03	00	03
014	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	8.5	06	219	7.0	00	3158.66	2126.97	41	10	23	16	07
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 70+ &/OR C.	6.0	07	202	6.6	01	2650.46	1596.47	52	05	17	12	11
090	SIMPLE PNEUMONIA & PLEURISY AGE 18-69 W/O C.C	6.2	08	187	6.7	01	3145.56	1444.59	81	01	10	04	02
320	KIDNEY & URINARY TRACT INFECTIONS AGE >=70 AND/OR C.C.	6.5	09	166	7.6	01	3435.18	1807.13	49	03	31	06	09
294	DIABETES AGE >=36	6.8	10	146	6.2	02	2097.87	1214.50	81	03	07	03	04
068	OTITIS MEDIA & URI AGE >=70 AND/OR C.C.	5.1	11	133	6.0	00	2362.36	1092.30	78	02	09	00	09
015	TRANSIENT ISCHEMIC ATTACKS AND PRECEREBRAL OCCLUSIONS	4.6	12	127	4.6	00	1828.02	969.89	78	01	11	00	07
183	ESOPHAGITIS,GASTROENT& MISC DIGEST DIS AGE 18-69 W/O C	4.0	13	124	4.3	00	1703.25	700.76	91	02	04	00	00
097	BRONCHITIS & ASTHMA AGE 18-69 W/O C.C.	5.1	14	109	5.1	00	2239.58	1004.47	89	03	04	00	01
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS AGE 70+ &/OR	4.9	15	106	4.9	00	2624.72	1388.78	78	09	06	01	03
079	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 70+ &/OR C.	9.6	16	99	8.8	01	4597.44	3868.55	53	10	23	10	03
088	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	6.6	17	97	6.9	01	3679.10	2010.25	76	06	06	07	04
243	MEDICAL BACK PROBLEMS	6.2	18	92	5.7	00	1936.85	933.54	88	05	03	01	02
069	OTITIS MEDIA & URI AGE 18-69 W/O C.C.	4.1	19	80	4.7	00	1858.21	625.32	93	00	05	00	01
122	CIRCULATORY DIS WITH AMI W/O CV COMP DISCH ALIVE	8.8	20	74	5.3	00	2782.37	1547.21	60	32	04	00	02
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 18-69 W/O C	4.9	21	74	5.2	00	1777.00	869.51	72	01	25	00	00
121	CIRCULATORY DISORDERS WITH AMI & CV COMP DISCH ALIVE	10.3	22	72	7.8	01	4229.89	2601.53	54	31	11	00	02
395	RED BLOOD CELL DISORDERS AGE >=18	4.7	23	72	6.0	00	2614.41	1102.96	84	04	09	01	00
416	SEPIECEMIA AGE >=18	8.4	24	72	7.7	01	4199.60	3074.60	37	04	27	26	04
134	HYPERTENSION	5.1	25	66	4.9	01	1842.04	882.11	87	01	06	01	03
174	GI HEMORRHAGE AGE >=70 AND/OR C.C	5.8	26	62	5.5	00	2873.68	1557.22	61	11	11	08	08
321	KIDNEY & URINARY TRACT INFECTIONS AGE 18-69 W/O C.C.	5.1	27	54	5.4	00	2271.70	1072.12	77	01	18	01	00
143	CHEST PAIN	3.5	28	53	3.5	00	1865.41	781.08	92	03	00	01	01
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS AGE <70 W/O	3.9	29	50	3.1	00	1448.48	777.44	80	20	00	00	00
207	DISORDERS OF THE BILIARY TRACT AGE >=70 AND/OR C.C.	5.4	30	49	5.2	00	2295.25	1332.11	65	26	08	00	00
141	SYNCOPE & COLLAPSE AGE >=70 AND/OR C.C.	4.4	31	48	4.2	00	1677.08	1054.98	87	02	04	00	06
087	PULMONARY EDEMA & RESPIRATORY FAILURE	7.0	32	43	6.2	00	3452.33	2656.35	60	09	06	18	04
180	GI OBSTRUCTION AGE >=70 AND/OR C.C.	5.4	33	43	7.4	02	3661.90	1238.42	53	32	06	02	04
065	DYSEQUILIBRIUM	3.8	34	37	4.9	02	1807.63	559.67	94	00	02	02	00
316	RENAL FAILURE	6.4	35	36	8.0	02	3512.76	2410.06	27	13	16	30	11
082	RESPIRATORY NEOPLASMS	6.5	36	35	6.9	00	3403.73	2350.59	25	20	08	40	05
130	PERIPHERAL VASCULAR DISORDERS AGE >=70 AND/OR C.C.	5.6	37	35	6.7	00	2482.82	1347.81	54	25	17	00	02
024	SEIZURE & HEADACHE AGE >=70 AND/OR C.C	5.0	38	32	5.9	00	2449.44	1602.14	75	03	12	00	09
080	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 18-69 W/O C	8.4	39	31	7.8	03	4265.15	2351.29	70	06	12	09	00
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	7.6	40	31	6.3	00	1935.88	1576.73	67	09	19	00	03
277	CELLULITIS AGE >=70 AND/OR C.C.	7.3	41	30	7.8	00	3350.88	1670.78	80	00	20	00	00
175	GI HEMORRHAGE AGE <70 W/O C.C.	4.7	42	29	3.4	00	1617.43	820.67	55	27	13	00	03
208	DISORDERS OF THE BILIARY TRACT AGE <70 W/O C.C.	4.0	43	29	3.5	00	1710.81	689.38	79	17	03	00	00
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 70+ &/OR	4.6	44	28	4.4	00	1452.52	867.82	82	07	07	03	03
123	CIRCULATORY DISORDERS WITH AMI, EXPIRED	3.0	45	27	3.2	00	2235.63	2579.82	00	00	00	100	00
132	ATHEROSCLEROSIS AGE >=70 AND/OR C.C.	5.3	46	27	5.7	00	2205.00	1290.12	85	07	03	03	00
142	SYNCOPE & COLLAPSE AGE <70 W/O C.C.	3.6	47	27	2.8	00	1181.49	727.16	92	03	03	00	00
421	VIRAL ILLNESS AGE >=18	4.6	48	27	5.3	00	2163.03	910.15	96	00	03	00	00
430	PSYCHOSES	10.6	49	27	9.8	07	3455.04	1469.94	55	18	22	00	03
099	RESPIRATORY SIGNS & SYMPTOMS AGE >=70 AND/OR C.C.	4.6	50	26	5.3	03	2376.86	1199.87	80	11	00	03	03
	TOTAL CASES FOR BEDTYPE			6202	6.3	00	2941.51	1627.35	70	06	11	05	04

STATE-WIDE DRG PROFILE

01/01/88 THRU 03/31/88

DRG	TITLE	GEOM ALOS	RNK	CASES	ALOS	%DAY OUTL	AVG CHARGES	AVG REIMB	% DISCHARGED TO HOM	TRANS	LTC	EXP	OTH
127	HEART FAILURE & SHOCK	6.7	01	2122	7.5	02	4099.58	2039.13	74	03	06	09	06
089	SIMPLE PNEUMONIA & PLEURISY AGE >=70 AND/OR C.C.	7.5	02	1930	8.6	01	5232.76	2599.48	69	03	12	10	04
096	BRONCHITIS & ASTHMA AGE >=70 AND/OR C.C.	6.0	03	1581	7.2	02	4147.71	1885.10	87	01	04	01	03
182	ESOPHAGITIS,GASTROENT& MISC DIGEST DIS AGE 70+ &/OR C.	4.7	04	1417	5.7	01	2802.89	1305.14	87	02	05	01	03
140	ANGINA PECTORIS	4.6	05	1387	4.9	01	2693.17	1151.26	87	05	02	00	03
014	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	8.5	06	1193	9.3	04	4742.52	2601.38	50	07	15	19	07
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 70+ &/OR C.	6.0	07	971	7.6	02	3606.15	1868.68	65	02	13	09	08
410	CHEMOTHERAPY	2.4	08	840	3.6	01	2052.11	1161.00	97	00	00	00	01
320	KIDNEY & URINARY TRACT INFECTIONS AGE >=70 AND/OR C.C.	6.5	09	706	8.0	02	4075.11	2003.08	62	02	20	05	08
015	TRANSIENT ISCHEMIC ATTACKS AND PRECEREBRAL OCCLUSIONS	4.6	10	696	5.1	01	2507.61	1065.09	86	02	07	00	03
243	MEDICAL BACK PROBLEMS	6.2	11	690	6.5	01	2523.09	1117.58	91	02	02	00	02
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS AGE 70+ &/OR	4.9	12	660	6.0	01	3508.38	1650.96	84	05	03	03	02
090	SIMPLE PNEUMONIA & PLEURISY AGE 18-69 W/O C.C.	6.2	13	654	6.9	00	3509.10	1587.81	83	01	09	01	02
183	ESOPHAGITIS,GASTROENT& MISC DIGEST DIS AGE 18-69 W/O C	4.0	14	610	4.3	00	1991.25	805.68	96	01	01	00	00
068	OTITIS MEDIA & URI AGE >=70 AND/OR C.C.	5.1	15	539	6.3	01	2777.59	1204.12	87	01	05	01	04
294	DIABETES AGE >=36	6.8	16	505	7.1	03	3116.90	1353.01	80	01	06	03	06
079	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 70+ &/OR C.	9.6	17	488	11.2	03	7184.39	4637.85	57	03	16	17	05
088	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	6.6	18	453	7.2	01	3990.14	2278.61	83	03	04	05	03
097	BRONCHITIS & ASTHMA AGE 18-69 W/O C.C.	5.1	19	447	5.9	01	2934.59	1199.41	93	01	02	00	02
468	UNRELATED OR PROC	11.5	20	445	14.3	08	12130.23	6258.84	76	01	05	10	05
122	CIRCULATORY DIS WITH AMI W/O CV COMP DISCH ALIVE	8.8	21	426	7.2	00	4441.61	2103.80	71	18	05	00	04
121	CIRCULATORY DISORDERS WITH AMI & CV COMP DISCH ALIVE	10.3	22	394	10.3	03	6924.85	3508.78	76	13	05	00	04
209	MAJOR JOINT AND LIMB REATTACHMENT PROCEDURES	14.4	23	390	13.5	04	11596.74	5711.71	64	02	20	02	09
082	RESPIRATORY NEOPLASMS	6.5	24	361	9.3	05	5270.09	2721.49	62	05	01	25	04
416	SEPTECEMIA AGE >=18	8.4	25	358	9.2	03	6449.17	3680.54	48	03	14	26	06
174	GI HEMORRHAGE AGE >=70 AND/OR C.C.	5.8	26	356	6.9	01	4095.78	1976.05	73	06	06	07	06
143	CHEST PAIN	3.5	27	352	3.6	01	2239.91	880.01	92	04	01	00	01
395	RED BLOOD CELL DISORDERS AGE >=18	4.7	28	348	6.2	02	3254.55	1390.89	86	02	05	01	04
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 18-69 W/O C	4.9	29	327	5.4	02	2159.56	997.52	79	02	12	00	04
336	TRANSURETHRAL PROSTATECTOMY AGE >=70 AND/OR C.C.	6.9	30	297	8.1	03	5401.49	2346.39	92	00	03	01	02
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS AGE <70 W/O	3.9	31	279	4.1	01	2036.98	990.33	89	05	03	00	01
141	SYNCOPE & COLLAPSE AGE >=70 AND/OR C.C.	4.4	32	268	5.1	00	2525.75	1207.78	90	01	02	00	04
125	CIRCULATORY DIS EXC AMI,WITH CARD CATH W/O COMPLEX DIA	2.9	33	259	3.6	05	3564.26	1481.50	98	01	00	00	00
148	MAJOR SMALL & LARGE BOWEL PROCEDURES AGE >=70 AND/OR C	15.1	34	259	15.8	05	15224.41	7905.46	73	00	05	11	08
134	HYPERTENSION	5.1	35	258	5.8	02	2404.58	1065.65	91	01	02	01	02
069	OTITIS MEDIA & URI AGE 18-69 W/O C.C.	4.1	36	253	5.0	01	2037.06	723.01	93	00	03	00	02
210	HIP & FEMUR PROCS EXCEPT MAJOR JOINT AGE 70+ &/OR C.C.	14.7	37	240	15.4	05	9395.37	5058.63	47	07	28	05	10
430	PSYCHOSES	10.6	38	233	11.4	08	2715.06	2092.14	76	04	08	00	09
087	PULMONARY EDEMA & RESPIRATORY FAILURE	7.0	39	223	7.4	01	5480.15	3287.71	65	06	04	19	04
337	TRANSURETHRAL PROSTATECTOMY AGE <70 W/O C.C.	5.7	40	222	5.8	03	3502.16	1492.25	99	00	00	00	00
130	PERIPHERAL VASCULAR DISORDERS AGE >=70 AND/OR C.C	5.6	41	221	7.1	00	3329.14	1602.33	70	13	08	04	04
123	CIRCULATORY DISORDERS WITH AMI, EXPIRED	3.0	42	213	4.4	03	5857.18	3184.13	00	00	00	100	00
197	TOTAL CHOLECYSTECTOMY W/O CDE AGE >=70 AND/OR C.C.	10.5	43	203	10.7	03	8317.80	4302.17	91	00	00	03	03
024	SEIZURE & HEADACHE AGE >=70 AND/OR C.C.	5.0	44	201	6.3	01	3482.02	1857.53	78	03	08	02	05
207	DISORDERS OF THE BILIARY TRACT AGE >=70 AND/OR C.C.	5.4	45	201	6.4	01	3489.82	1662.86	75	10	02	03	03
321	KIDNEY & URINARY TRACT INFECTIONS AGE 18-69 W/O C.C.	5.1	46	195	5.7	00	2645.44	1269.76	81	00	15	01	01
239	PATHOLOGICAL FRACTURES & MUSCULOSKEL & CONNTISSMALIG	7.9	47	190	10.1	05	3962.25	2032.28	80	03	06	04	05
180	GI OBSTRUCTION AGE >=70 AND/OR C.C.	5.4	48	181	7.4	02	3882.91	1716.77	71	11	04	07	04
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	7.6	49	177	7.7	02	2787.30	1836.36	71	01	17	02	06
099	RESPIRATORY SIGNS & SYMPTOMS AGE >=70 AND/OR C.C.	4.6	50	175	5.4	02	3166.19	1472.33	80	04	05	05	04
112	VASCULAR PROCEDURES EXCEPT MAJOR RECONSTRUCTION	8.1	51	174	7.8	02	8188.78	4710.11	91	01	00	06	01

STATE DE DRG PROFILE MISSISSIPPI FOUN ON FOR MEDICAL CARE RUN DATE 0 5/88

STATE-WIDE DRG PROFILE

01/01/88 THRU 03/31/88

DRG	TITLE	GEOM ALOS	RNK	CASES	ALOS	%DAY OUTL	AVG CHARGES	AVG REIMB	% DISCHARGED TO HOM	TRANS	LTC	EXP	OTH
142	SYNCOPE & COLLAPSE AGE <70 W/O C.C.	3.6	52	170	3.8	01	1935.19	817.71	95	01	02	00	01
113	AMPUTATION FOR CIRC SYS DIS EXCEPT UPPER LIMB & TOE	16.8	53	168	14.0	04	8497.36	5580.58	51	02	26	11	07
144	OTHER CIRCULATORY DIAGNOSES WITH C.C.	6.2	54	167	6.8	01	4720.48	2497.01	73	03	05	13	04
065	DYSEQUILIBRIUM	3.8	55	166	4.4	02	2013.81	650.76	97	00	00	00	01
116	PERMANENT CARDIAC PACEMAKER IMPLANT W/O AMI OR CHF	7.7	56	166	7.8	01	11591.64	6593.66	91	00	03	00	03
277	CELLULITIS AGE >=70 AND/OR C.C.	7.3	57	166	8.3	02	3916.96	1839.74	80	01	10	00	07
005	EXTRACRANIAL VASCULAR PROCEDURES	7.9	58	155	7.6	01	6628.48	3805.66	96	00	00	02	01
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >=70 AND/OR C.C.	4.3	59	153	6.3	01	3499.52	1815.07	79	04	07	05	03
110	MAJOR RECONSTRUCTIVE VASCULAR PROCS AGE 70+ &/OR C.C.	12.9	60	150	15.3	06	16139.25	9710.21	79	02	05	06	06
106	CORONARY BYPASS WITH CARDIAC CATH	14.6	61	149	16.5	04	25732.68	14788.47	92	00	00	06	00
421	VIRAL ILLNESS AGE >=18	4.6	62	149	5.3	02	2478.16	1028.84	93	00	02	00	03
316	RENAL FAILURE	6.4	63	148	7.8	02	3801.37	2575.62	51	09	06	29	03
080	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 18-69 W/O C	8.4	64	144	9.0	02	4951.53	2601.41	77	03	11	05	02
124	CIRCULATORY DIS EXC AMI,WITH CARD CATH & COMPLEX DIAG	5.0	65	141	5.8	01	5453.86	2641.82	82	06	09	00	00
172	DIGESTIVE MALIGNANCY AGE >=70 AND/OR C.C.	6.7	66	139	11.8	11	5667.78	2665.91	48	08	06	29	07
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	6.4	67	135	7.6	02	5034.97	2047.13	81	04	04	07	02
154	STOMACH, ESOPHAGEAL & DUODENAL PROCS AGE 70+ &/OR C.C.	11.3	68	130	14.8	06	15826.59	10036.16	69	00	05	16	07
175	GI HEMORRHAGE AGE <70 W/O C.C.	4.7	69	129	4.5	01	2345.37	1120.01	83	08	06	00	00
162	INGUINAL & FEMORAL HERNIA PROCEDURES AGE 18-69 W/O C.C	3.6	70	127	3.5	01	2392.09	720.32	99	00	00	00	00
161	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >=70 AND/OR C	4.4	71	125	4.9	01	3758.43	1439.38	93	00	02	00	02
442	OTHER OR PROCEDURES FOR INJURIES AGE >=70 AND/OR C.C.	6.0	72	121	6.9	02	7009.61	4957.50	91	00	02	04	01
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 70+ &/OR C.	5.3	73	120	6.8	00	3724.21	1927.16	73	10	08	04	04
211	HIP & FEMUR PROCS EXCEPT MAJOR JOINT AGE 18-69 W/O C.C	12.7	74	119	11.7	00	6682.06	3329.00	49	05	36	00	08
198	TOTAL CHOLECYSTECTOMY W/O CDE AGE <70 W/O C.C.	8.0	75	112	7.3	03	4555.41	2425.01	98	00	00	00	00
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	6.8	76	112	10.6	08	5226.69	2410.11	51	03	05	39	00
076	OR PROC ON THE RESP SYSTEM EXCEPT MAJOR CHEST WITH C.C	10.1	77	111	11.2	05	8757.87	5060.02	81	02	02	11	01
177	UNCOMPLICATED PEPTIC ULCER >=70 AND/OR C.C.	5.4	78	107	5.6	00	2653.10	1329.80	93	01	02	00	01
131	PERIPHERAL VASCULAR DISORDERS AGE <70 W/O C.C.	4.4	79	106	6.1	03	2577.76	1019.97	88	05	03	00	00
025	SEIZURE & HEADACHE AGE 18-69 W/O C.C.	4.0	80	105	4.0	00	1771.68	867.03	87	01	02	01	05
101	OTHER RESPIRATORY DIAGNOSES AGE >=70 AND/OR C.C.	6.0	81	105	7.0	00	4159.23	1808.51	74	03	06	08	06
128	DEEP VEIN THROMBOPHLEBITIS	8.6	82	104	7.8	00	2883.29	1513.28	95	00	01	00	02
236	FRACTURES OF HIP & PELVIS	8.8	83	102	8.4	01	2806.58	1487.86	48	19	25	01	04
359	INCISIONAL TUBAL INTERRUPTION FOR NON-MALIGNANCY	2.8	84	102	6.7	03	4026.06	1645.26	100	00	00	00	00
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	8.8	85	99	13.6	07	22300.51	8979.96	35	04	05	47	08
078	PULMONARY EMBOLISM	9.5	86	97	11.0	01	6737.69	3201.34	74	04	07	06	08
157	ANAL AND STOMAL PROCEDURES AGE >=70 AND/OR C.C.	4.8	87	94	6.4	01	3771.60	1804.04	92	01	03	00	03
244	BONE DISEASES & SEPTIC ARTHROPATHY AGE >=70 AND/OR C.C	6.1	88	93	6.0	00	2143.16	1261.44	84	06	01	01	06
181	GI OBSTRUCTION AGE <70 W/O C.C.	4.5	89	92	4.7	01	2156.90	792.97	84	10	03	00	01
449	POISONING AND TOXIC EFFECTS OF DRUGS AGE >=70 AND/OR C	4.7	90	92	6.5	01	3738.55	1521.38	82	02	04	04	06
310	TRANSURETHRAL PROCEDURES AGE >=70 AND/OR C.C.	4.2	91	90	5.9	01	4378.68	1797.19	91	02	05	00	01
132	ATHEROSCLEROSIS AGE >=70 AND/OR C.C.	5.3	92	89	6.5	01	3047.00	1432.88	74	05	07	06	05
215	BACK & NECK PROCEDURES AGE <70 W/O C.C.	10.2	93	89	9.7	02	5227.41	3134.94	100	00	00	00	00
271	SKIN ULCERS	10.0	94	87	11.2	04	4744.63	2491.17	65	03	16	05	09
315	OTHER KIDNEY & URINARY TRACT OR PROCEDURES	9.7	95	87	9.5	03	9848.88	6414.85	77	00	06	10	05
426	DEPRESSIVE NEUROSES	7.8	96	86	6.9	01	2179.36	1234.64	88	01	04	01	04
012	DEGENERATIVE NERVOUS SYSTEM DISORDERS	7.8	97	85	6.7	01	2763.72	1876.19	74	02	11	07	04
208	DISORDERS OF THE BILIARY TRACT AGE <70 W/O C.C.	4.0	98	83	4.1	01	2012.44	883.39	86	08	04	00	00
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 70+ &/OR	4.6	99	83	5.7	02	2099.03	949.82	79	03	07	03	06
403	LYMPHOMA OR LEUKEMIA AGE >=70 AND/OR C.C.	6.7	100	83	12.8	13	8251.10	3810.04	59	03	06	30	01
323	URINARY STONES AGE >=70 AND/OR C.C.	3.7	101	82	4.1	00	3725.70	1293.71	84	07	03	01	03
263	SKIN GRAFTS &/OR DEBRID ULCER OR CELLULITIS AGE 70+ &/	16.0	102	81	16.3	09	9251.99	5808.96	59	04	17	06	12

STATE-WIDE DRG PROFILE MISSISSIPPI FOUNDATION FOR MEDICAL CARE RUN DATE 5/88

STATE-WIDE DRG PROFILE

01/01/88 THRU 03/31/88

DRG	TITLE	GEOM ALOS	RNK	CASES	ALOS	%DAY OUTL	AVG CHARGES	AVG REIMB	% DISCHARGED TO HOM	TRANS	LTC	EXP	OTH
425	ACUTE ADJUST REACT & DISTURBANCE OF PSYCHOSOCIAL DYSFU	4.8	103	81	5.3	03	2508.76	1103.04	83	04	02	02	06
178	UNCOMPLICATED PEPTIC ULCER <70 W/O C.C.	4.6	104	80	4.6	03	2024.52	886.04	98	00	00	00	01
281	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 18-69 W/O	3.4	105	79	4.3	02	1683.07	512.11	87	01	08	00	02
254	FX,SPRNS,STRNS & DISL OF UPARM,LOWLEG EX FOOT;18-69 W/	4.0	106	77	4.3	01	1434.25	570.94	75	09	09	00	06
278	CELLULITIS AGE 18-69 W/O C.C.	6.2	107	77	6.5	00	2931.08	1207.20	84	01	09	00	05
356	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	7.0	108	77	6.1	00	3661.71	1442.10	100	00	00	00	00
158	ANAL AND STOMAL PROCEDURES AGE >=70 AND/OR C,C.	3.9	109	76	4.5	00	2321.38	870.55	100	00	00	00	00
039	LENS PROCEDURES	2.1	110	73	2.3	02	3376.38	963.82	90	00	06	00	02
245	BONE DISEASES & SEPTIC ARTHROPATHY AGE <70 W/O C.C.	5.1	111	73	5.6	01	1846.75	800.00	84	00	06	00	08
434	SUBSTANCE ABUSE,INTOX, OR INDUCED MENTAL SYN EXC DEPEN	5.4	112	73	8.4	06	4096.76	1491.35	82	04	04	01	08
022	HYPERTENSIVE ENCEPHALOPATHY	5.0	113	71	5.4	00	2420.37	1161.55	91	01	04	00	02
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 18-69 W/O C.C.	3.3	114	71	3.9	01	1924.62	724.29	90	05	00	02	01
463	SIGNS & SYMPTOMS WITH C.C.	5.9	115	71	5.9	04	2581.76	1433.00	81	01	08	02	05
149	MAJOR SMALL & LARGE BOWEL PROCEDURES AGE <70 W/O C.C.	12.6	116	68	12.1	04	7875.01	4340.96	86	00	02	04	05
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISS	4.7	117	68	5.1	01	2209.49	849.52	88	04	05	00	01
257	TOTAL MASTECTOMY FOR MALIGNANCY AGE >=70 AND/OR C.C.	7.8	118	66	7.0	01	4891.18	2144.95	93	00	01	00	04
258	TOTAL MASTECTOMY FOR MALIGNANCY AGE <70 W/O C.C.	6.9	119	65	6.0	00	3895.60	1647.20	93	00	03	00	03
311	TRANSURETHRAL PROCEDURES AGE <70 W/O C.C.	3.3	120	65	4.1	04	2691.34	1151.15	95	01	01	00	01
120	OTHER OR PROCEDURES ON THE CIRCULATORY SYSTEM	11.2	121	63	16.7	19	12657.49	6179.90	58	03	14	15	07
010	NERVOUS SYSTEM NEOPLASMS AGE >=70 AND/OR C.C.	7.7	122	62	12.3	09	5325.03	2683.33	50	06	06	25	11
066	EPISTAXIS	3.3	123	61	2.8	00	1318.05	609.29	95	04	00	00	00
240	CONNECTIVE TISSUE DISORDERS AGE >=70 AND/OR C.C.	7.2	124	61	10.2	04	4721.95	2490.15	86	01	03	04	03
419	FEVER OF UNKNOWN ORIGIN AGE >=70 AND/OR C.C.	6.1	125	61	9.4	04	5100.49	2150.39	65	06	16	06	04
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	4.8	126	60	6.7	05	3321.58	1216.50	93	01	03	00	01
001	CRANIOTOMY AGE >=18 EXCEPT FOR TRAUMA	16.0	127	59	19.4	16	15486.26	9893.86	77	01	03	10	06
016	NONSPECIFIC CEREBROVASCULAR DISORDERS WITH C.C.	6.7	128	59	7.9	03	3874.29	2148.34	66	00	06	08	18
324	URINARY STONES AGE <70 W/O C.C.	2.7	129	59	3.1	00	1455.17	753.36	93	06	00	00	00
415	OR PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	14.4	130	59	16.7	11	12279.40	8771.41	61	01	15	13	08
085	PLEURAL EFFUSION AGE >=70 AND/OR C.C.	7.2	131	58	8.8	05	4320.86	2428.01	81	05	05	06	01
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, AGE 70+ &/OR C.C	5.6	132	58	8.7	03	3430.67	1884.35	60	06	06	22	03
075	MAJOR CHEST PROCEDURES	13.3	133	56	17.3	05	18649.30	7670.93	82	03	00	07	07
325	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 70+ &/OR C	4.5	134	56	5.3	01	2340.24	1218.93	78	05	07	00	08
018	CRANIAL & PERIPHERAL NERVE DISORDERS AGE >=70 AND/OR C	5.8	135	55	7.7	03	3935.94	1995.51	83	03	07	00	05
102	OTHER RESPIRATORY DIAGNOSES AGE <70	4.2	136	54	5.1	00	2661.72	1058.72	88	07	01	01	00
195	TOTAL CHOLECYSTECTOMY WITH CDE AGE >=70 AND/OR C.C.	13.1	137	54	14.8	01	12513.68	5934.58	72	01	07	05	12
042	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	3.0	138	52	2.9	01	3479.60	1363.83	94	01	00	00	03
100	RESPIRATORY SIGNS & SYMPTOMS AGE <70 W/O C.C.	3.6	139	52	3.2	00	1932.98	784.19	96	01	00	00	01
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	7.7	140	52	10.2	03	4749.41	2750.43	78	01	01	13	03
107	CORONARY BYPASS W/O CARDIAC CATH	12.7	141	51	12.8	05	27125.05	12222.86	90	05	00	03	00
452	COMPLICATIONS OF TREATMENT AGE >=70 AND/OR C.C.	4.6	142	51	5.9	01	3353.57	2371.04	90	00	07	00	01
092	INTERSTITIAL LUNG DISEASE AGE >=70 AND/OR C.C.	6.7	143	50	6.7	00	4381.18	2722.61	84	04	02	08	02
205	DISORDERS OF LIVER EXC MALIG,CIRR,ALC HEPA AGE 70+ &/O	6.7	144	49	8.0	02	4401.24	2484.64	75	02	00	18	04
225	FOOT PROCEDURES	3.9	145	49	6.9	12	4806.56	1397.50	95	00	02	00	02
253	FX,SPRNS,STRNS & DISL OF UPARM,LOWLEG EX FOOT;70+ &/OR	5.4	146	49	6.5	02	1975.79	1324.08	63	04	22	00	10
111	MAJOR RECONSTRUCTIVE VASCULAR PROCEDURES AGE <70 W/O C	11.1	147	48	8.8	00	7485.24	5617.36	100	00	00	00	00
019	CRANIAL & PERIPHERAL NERVE DISORDERS AGE <70 W/O C.C.	4.9	148	46	5.1	00	2029.00	1109.92	91	04	02	00	02
150	PERITONEAL ADHESIOLYSIS AGE >=70 AND/OR C.C.	12.6	149	46	16.6	08	15810.95	6958.32	71	00	04	08	15
160	HERNIA PROCS EXCEPT INGUINAL & FEMORAL AGE 18-69 W/O C	5.0	150	46	4.7	00	3030.00	1175.50	95	00	04	00	00
450	POISONING AND TOXIC EFFECTS OF DRUGS AGE 18-69 W/O C.C	3.3	151	46	3.7	02	1631.10	896.39	84	06	02	02	04
159	HERNIA PROCS EXCEPT INGUINAL & FEMORAL AGE 70+ &/OR C	6.3	152	45	6.7	02	5327.76	2363.70	88	00	06	02	02
214	BACK & NECK PROCEDURES AGE >=70 AND/OR C.C	13.1	153	45	13.2	04	9384.63	5373.89	80	00	08	02	08

STAiL 'DE DRG PROFILE   MISSISSIPPI FOUND TION FOR MEDICAL CARE   RUN DATE (5/88

STATE-WIDE DRG PROFILE

01/01/88 THRU 03/31/88

DRG	TITLE	GEOM ALOS	RNK	CASES	ALOS	%DAY OUTL	AVG CHARGES	AVG REIMB	% DISCHARGED TO HOM	TRANS	LTC	EXP	OTH
358	UTERUS & ADENEXA PROC FOR NON-MALIG EXCEPT TUBAL INTER	6.9	154	45	8.8	02	5700.56	2720.34	97	00	00	00	02
248	TENDONITIS, MYOSITIS & BURSITIS	4.8	155	44	4.8	00	1941.51	913.47	95	00	00	00	04
341	PENIS PROCEDURES	4.3	156	42	5.1	00	4426.34	2035.67	97	00	00	00	02
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS AGE 70+ &/OR	5.5	157	42	10.9	04	7073.60	2944.73	78	02	02	04	11
408	MYELOPROLIF DIS OR POORLY DIFF NEOPL WITH MINOR ORPROC	5.3	158	42	6.9	09	4424.95	2265.53	85	02	04	02	04
034	OTHER DISORDERS OF NERVOUS SYSTEM AGE >=70 AND/OR C.C	6.0	159	41	9.5	07	6247.10	2843.83	78	04	00	09	07
073	OTHER EAR, NOSE & THROAT DIAGNOSES AGE >=18	3.4	160	40	7.2	02	4632.70	1817.80	85	00	07	07	00
176	COMPLICATED PEPTIC ULCER	6.3	161	40	7.1	02	3954.30	2032.30	72	12	05	05	05
269	OTHER SKIN, SUBCUT TISS & BREAST OR PROC AGE 70+ &/OR	5.4	162	40	7.7	02	4467.34	3398.04	67	00	17	02	12
217	WND DEBRI & SKN GRFT EXC HAND,FOR MUSCSKEL & CONNTISSD	10.3	163	39	16.3	15	9734.49	6630.42	74	00	10	02	12
036	RETINAL PROCEDURES	4.1	164	38	3.4	00	2775.46	1436.98	100	00	00	00	00
094	PNEUMOTHORAX AGE >=70 AND/OR C.C.	7.6	165	38	12.8	07	9862.27	3355.49	76	05	00	07	10
290	THYROID PROCEDURES	5.0	166	38	5.3	05	4040.81	1577.96	100	00	00	00	00
304	KIDNEY,URETER & MAJ BLDR PROC FOR NON-MALIG;70+ &/OR C	10.7	167	38	14.1	02	9492.23	5771.09	86	00	05	02	05
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 18-69 W/O C	3.9	168	38	4.6	00	2478.90	1027.55	84	07	02	02	02
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	11.8	169	37	10.5	05	5264.23	3646.55	64	02	16	00	16
303	KIDNEY,URETER & MAJOR BLADDER PROCEDURE FOR NEOPLASM	14.1	170	37	14.9	02	13356.65	7014.75	94	00	00	02	02
413	OTHR MYELOPROLIF DIS OR POORLY DIFF NEOPL DX;>=70 &/OR	6.9	171	37	9.5	02	5233.06	2893.94	45	05	05	37	05
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	7.9	172	37	10.5	05	5987.59	3460.43	78	00	00	18	02
145	OTHER CIRCULATORY DIAGNOSES W/O C.C.	5.0	173	36	4.1	00	2538.80	1197.50	77	11	00	05	05
262	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	2.4	174	36	2.3	05	2019.57	587.69	97	00	02	00	00
454	OTHER INJURIES, POISONINGS & TOXIC EFF DX AGE 70+ &/OR	4.6	175	36	7.9	05	5674.55	1910.20	63	00	25	05	05
334	MAJOR MALE PELVIC PROCEDURES WITH C.C.	12.2	176	35	12.5	02	8551.89	4224.41	88	00	00	00	11
348	BENIGN PROSTATIC HYPERTROPHY AGE >=70 AND/OR C.C.	3.9	177	35	6.4	00	3128.12	1152.66	77	05	05	05	05
083	MAJOR CHEST TRAUMA AGE >=70 AND/OR C.C.	6.6	178	34	8.2	02	3521.40	1669.14	70	02	14	02	08
193	BILIARY TRACT PROC EXC TOT CHOLECYSTECTOMY AGE 70+ &/O	15.6	179	34	15.7	08	12820.08	7440.25	55	02	11	14	14
435	SUBSTANCE DEPENDENCE, DETOX. &/OR OTHER SYMPTOMATIC TR	6.8	180	34	7.9	08	2218.62	1300.27	94	00	05	00	00
219	LOWER EXTREM & HUMER PROC EXC HIP,FOOT,FEMUR;18-69 W/O	6.7	181	33	6.5	00	3972.73	1918.83	90	00	00	00	09
306	PROSTATECTOMY AGE >=70 AND/OR C.C.	8.1	182	33	9.3	00	6853.02	3157.81	100	00	00	00	00
256	OTHER DIAGNOSES OF MUSCULOSKEL SYSTEM & CONNECTIVE TIS	4.9	183	32	5.6	03	2419.81	1092.19	75	03	06	15	00
300	ENDOCRINE DISORDERS AGE >=70 AND/OR C.C.	6.8	184	32	8.6	03	3751.35	2437.29	68	03	12	12	03
318	KIDNEY & URINARY TRACT NEOPLASMS AGE >=70 AND/OR C.C.	5.5	185	32	9.5	06	4444.76	2559.46	65	09	03	18	03
409	RADIOTHERAPY	6.8	186	32	10.5	25	6235.87	3341.42	81	00	00	09	09
146	RECTAL RESECTION AGE >=70 AND/OR C.C.	16.5	187	31	21.0	12	22795.25	8654.06	54	03	16	22	03
218	LOWER EXTREM & HUMER PROC EXC HIP,FOOT,FEMUR;70+ &/OR	8.8	188	31	8.5	00	6582.88	3415.22	90	00	09	00	00
251	FX,SPRNS,STRNS & DISL OF FOREARM,HAND,FOOT AGE 18-69 W	2.5	189	31	2.4	00	1112.96	496.90	80	09	06	00	03
460	NON-EXTENSIVE BURNS W/O OR PROCEDURE	7.5	190	31	12.0	12	4664.01	2348.75	74	00	09	03	12
222	KNEE PROCEDURES AGE <70 W/O C.C.	3.4	191	30	5.5	03	4398.57	1646.21	93	00	06	00	00
270	OTHER SKIN, SUBCUT TISS & BREAST OR PROC AGE <70 W/O C	3.8	192	30	4.7	00	3129.13	1116.25	96	00	03	00	00
453	COMPLICATIONS OF TREATMENT AGE <70 W/O C.C.	4.2	193	30	4.9	00	2224.30	1128.95	83	03	06	00	06
467	OTHER FACTORS INFLUENCING HEALTH STATUS	3.4	194	30	3.3	00	1850.06	964.74	90	03	00	03	03
017	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O C.C.	5.6	195	29	6.0	00	2250.59	979.55	75	10	06	00	06
170	OTHER DIGESTIVE SYSTEM PROCEDURES AGE >=70 AND/OR C.C.	12.2	196	29	17.7	06	18677.23	7592.65	62	00	06	31	00
364	D&C,CONIZATION EXCEPT FOR MALIGNANCY	2.2	197	29	4.1	06	2140.76	703.85	93	00	03	00	03
443	OTHER OR PROCEDURES FOR INJURIES AGE <70 W/O C.C.	5.5	198	29	5.7	00	4619.39	2739.79	96	00	00	00	03
029	TRAUMATIC STUPOR & COMA <1 HR AGE 18-69 W/O C.C.	3.6	199	28	3.3	00	1380.78	930.23	82	03	14	00	00
053	SINUS & MASTOID PROCEDURES AGE >=18	3.0	200	28	3.1	03	3320.80	1187.95	96	00	03	00	00
133	ATHEROSCLEROSIS AGE <70 W/O C.C.	3.8	201	28	4.6	03	1756.94	960.18	85	07	00	00	07
223	UPPER EXTREMITY PROC EXC HUMERUS & HAND AGE 70+ &/OR C	5.2	202	28	6.5	03	4603.77	2852.05	89	00	07	00	03
241	CONNECTIVE TISSUE DISORDERS AGE <70 W/O C.C.	6.2	203	28	5.5	03	2127.19	1221.12	92	00	00	00	07
274	MALIGNANT BREAST DISORDERS AGE >=70 AND/OR C.C.	7.0	204	28	7.6	03	3561.13	2114.19	50	03	07	39	00

STA IDE PRO MISSISSIPPI FOUNDATION FOR MEDICAL CARE RUN DATE [illegible]5/88

STATE-WIDE DRG PROFILE

01/01/88 THRU 03/31/88

DRG	TITLE	GEOM ALOS	RNK	CASES	ALOS	%DAY OUTL	AVG CHARGES	AVG REIMB	% DISCHARGED TO				
									HOM	TRANS	LTC	EXP	OTH
326	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 18-69 W/O	3.5	205	20	3.6	00	1626.39	663.13	96	03	00	00	00
233	OTHER MUSCULOSKEL SYS & CONN TISS OR PROC;70+ &/OR C.C	6.1	206	27	10.8	03	8693.38	4046.27	66	00	07	11	14
284	MINOR SKIN DISORDERS AGE <70 W/O C.C.	3.8	207	27	4.0	00	1960.44	683.87	96	03	00	00	00
335	MAJOR MALE PELVIC PROCEDURES W/O C.C.	11.0	208	27	9.4	00	6384.04	3078.81	100	00	00	00	00
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM AGE 70+ &/OR C.	4.9	209	27	9.4	11	5219.91	2500.46	48	03	07	37	03
397	COAGULATION DISORDERS	6.0	210	27	6.2	00	4167.82	2194.74	85	00	07	03	03
020	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	7.7	211	26	8.8	03	5097.99	3350.71	88	07	03	00	00
032	CONCUSSION AGE 18-69 W/O C.C.	2.8	212	26	2.8	00	1229.89	422.83	84	00	11	00	03
272	MAJOR SKIN DISORDERS AGE >=70 AND/OR C.C.	7.2	213	26	13.7	15	6478.06	2659.55	84	00	03	11	00
312	URETHRAL PROCEDURES, AGE >=70 AND/OR C.C.	4.4	214	26	5.0	00	3175.74	1584.82	96	00	03	00	00
338	TESTES PROCEDURES, FOR MALIGNANCY	4.9	215	26	8.8	03	5016.19	1762.00	84	00	07	07	00
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	7.5	216	26	10.4	11	4768.48	2363.22	69	07	07	11	03
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE > 17	7.5	217	26	12.4	19	14097.59	7521.50	46	11	00	42	00
028	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >=70 AND/OR C.	5.0	218	25	5.2	00	2476.56	2140.19	60	08	16	08	08
129	CARDIAC ARREST, UNEXPLAINED	3.8	219	25	5.1	04	4997.13	3449.70	36	00	04	56	04
234	OTHER MUSCULOSKEL & CONN TISS OR PROC AGE <70 W/O C.C.	5.3	220	25	7.1	00	4251.53	1708.76	92	04	04	00	00
360	VAGINA, CERVIX & VULVA PROCEDURES	3.4	221	25	10.1	12	5913.55	1852.13	80	04	04	08	04
404	LYMPHOMA OR LEUKEMIA AGE 18-69 W/O C.C.	5.0	222	25	5.8	00	2820.13	1629.40	96	04	00	00	00
152	MINOR SMALL & LARGE BOWEL PROCEDURES AGE >=70 AND/OR C	8.5	223	24	8.2	04	5933.29	3592.11	91	00	04	04	00
155	STOMACH, ESOPHAGEAL & DUODENAL PROCS AGE 18-69 W/O C.C	8.9	224	24	11.5	08	9219.18	4134.61	79	04	08	00	08
265	SKIN GRAFTS &/OR DEBRID EXCEPT ULCER OR CELLULITIS WIT	7.3	225	24	11.2	12	5952.99	3834.81	87	00	08	00	04
266	SKIN GRAFTS &/OR DEBRID EXCEPT ULCER OR CELLULITIS W/O	4.0	226	24	3.5	00	2348.33	1203.06	91	04	04	00	00
474	RESPIRATORY SYSTEM DIAGNOSIS WITH TRACHEOSTOMY	33.3	227	24	40.4	25	64041.85	34472.27	33	04	04	45	12
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 70+ &/OR C	5.2	228	23	6.4	04	3463.29	1771.41	65	17	08	04	04
224	UPPER EXTREMITY PROC EXC HUMERUS & HAND AGE <70 W/O C.	4.1	229	23	2.6	00	2239.39	1161.18	95	00	04	00	00
231	LOCAL EXC & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FE	3.8	230	23	2.8	00	2515.11	1711.94	95	00	00	00	04
283	MINOR SKIN DISORDERS AGE >=70 AND/OR C.C.	5.0	231	23	6.5	04	2719.61	1357.09	82	04	04	00	08
420	FEVER OF UNKNOWN ORIGIN AGE 18-69 W/O C.C.	5.6	232	23	5.9	00	2637.69	1280.52	91	00	08	00	00
055	MISCELLANEOUS EAR, NOSE & THROAT PROCEDURES	2.1	233	22	2.2	09	2338.89	702.00	100	00	00	00	00
064	EAR, NOSE & THROAT MALIGNANCY	4.7	234	22	4.5	00	2456.86	2304.62	63	04	00	22	09
104	CARDIAC VALVE PROCEDURE WITH PUMP & WITH CARDIAC CATH	17.6	235	22	23.5	18	42944.13	21119.80	77	00	04	18	00
118	CARDIAC PACEMAKER PULSE GENERATOR REPLACEMENT ONLY	3.4	236	22	5.5	04	8180.50	4099.60	100	00	00	00	00
273	MAJOR SKIN DISORDERS AGE <70 W/O C.C.	6.6	237	22	5.5	00	2807.11	1166.70	86	04	04	00	04
444	MULTIPLE TRAUMA AGE >=70 AND/OR C.C.	5.3	238	22	5.9	00	1936.52	1230.12	77	04	13	04	00
077	OR PROC ON THE RESP SYSTEM EXCEPT MAJOR CHEST W/O C.C	6.9	239	21	2.9	00	4794.08	2182.29	90	04	00	00	04
115	PERMANENT CARDIAC PACEMAKER IMPLANT WITH AMI OR CHF	13.8	240	21	14.6	04	17137.56	9436.24	71	00	04	09	14
185	DENTAL & ORAL DIS EXC EXTRACTIONS & RESTORATIONS,AGE >	4.3	241	21	6.4	04	2679.04	1383.99	90	00	00	00	09
246	NON-SPECIFIC ARTHROPATHIES	5.4	242	21	4.6	00	1640.00	955.07	95	00	00	00	04
301	ENDOCRINE DISORDERS AGE <70 W/O C.C.	5.1	243	21	6.1	04	3025.87	1292.48	80	09	00	00	09
354	NON-RADICAL HYSTERECTOMY AGE >=70 AND/OR C.C	8.8	244	21	12.9	04	7617.66	3681.46	90	00	04	00	04
369	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	3.9	245	21	2.9	00	1290.99	751.07	85	00	14	00	00
002	CRANIOTOMY FOR TRAUMA AGE >=18	13.4	246	20	14.7	10	12091.05	10754.16	75	00	05	20	00
401	LYMPHOMA OR LEUKEMIA WITH OTHER OR PROC AGE 70+ &/OR C	8.1	247	20	11.8	00	6206.14	5012.50	90	00	05	05	00
464	SIGNS & SYMPTOMS W/O C.C.	5.0	248	20	4.5	00	1897.79	728.45	80	00	00	10	10
007	PERIPH & CRANIAL NERV & OTHR NERV SYS PROC AGE 70+ &/O	6.8	249	19	13.8	00	6519.70	5994.11	68	05	05	10	10
173	DIGESTIVE MALIGNANCY AGE <70 W/O C.C.	5.3	250	19	5.3	00	2065.09	1318.50	84	05	00	10	00
221	KNEE PROCEDURES AGE >=70 AND/OR C.C.	4.7	251	19	7.3	00	4934.97	3141.66	89	00	00	00	10
308	MINOR BLADDER PROCEDURES AGE >=70 AND/OR C.C.	6.0	252	19	9.4	05	6260.69	2921.57	84	00	05	00	10
309	MINOR BLADDER PROCEDURES AGE <70 W/O C.C.	4.6	253	19	5.1	00	2990.99	1656.63	100	00	00	00	00
011	NERVOUS SYSTEM NEOPLASMS AGE <70 W/O C.C.	6.0	254	18	4.8	00	2458.79	1531.41	72	05	05	11	05
023	NONTRAUMATIC STUPOR & COMA	5.2	255	18	9.8	11	4365.72	2300.88	50	00	27	11	11

STATE-WIDE DRG PROFILE

01/01/88 THRU 03/31/88

DRG	TITLE	GEOM ALOS	RNK	CASES	ALOS	XDAY OUTL	AVG CHARGES	AVG REIMB	% DISCHARGED TO HOM	TRANS	LTC	EXP	OTH
206	DISORDERS OF LIVER EXC MALIG,CIRR,ALC HEPA AGE <70 W/O	5.0	256	18	3.9	00	1773.37	1052.00	66	22	05	00	05
264	SKIN GRAFTS &/OR DEBRID ULCER OR CELLULITIS AGE <70 W/	14.9	257	18	16.4	16	5378.73	3863.71	77	00	16	00	05
287	SKIN GRAFTS & WOUND DEBRIDE FOR ENDOC,NUTRIT & METAB D	15.2	258	18	11.9	05	5319.47	4986.43	83	00	11	00	05
040	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >=18	2.1	259	17	3.0	11	2483.45	792.98	100	00	00	00	00
045	NEUROLOGICAL EYE DISORDERS	3.6	260	17	3.2	00	2606.37	1041.19	100	00	00	00	00
160	PROCEDURES ON THE MOUTH AGE >=70 AND/OR C.C.	4.1	261	17	3.7	00	3544.72	3104.78	94	00	00	00	05
228	GANGLION (HAND) PROCEDURES	1.9	262	17	3.2	00	2573.94	1601.22	94	00	05	00	00
229	HAND PROCEDURES EXCEPT GANGLION	2.9	263	17	2.1	00	1941.86	822.45	100	00	00	00	00
235	FRACTURES OF FEMUR	10.3	264	17	6.0	00	2722.33	2352.33	52	05	35	05	00
307	PROSTATECTOMY AGE <70 W/O C.C.	6.4	265	17	6.3	00	4085.49	1770.86	100	00	00	00	00
339	TESTES PROCEDURES, NON-MALIGNANT AGE >=18	3.4	266	17	2.0	00	2326.69	921.24	94	00	00	05	00
363	D&C,CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	3.6	267	17	7.9	11	5292.51	1445.94	88	00	00	05	05
093	INTERSTITIAL LUNG DISEASE AGE <70 W/O C.C.	5.4	268	16	5.0	00	2742.19	1558.39	87	00	06	06	00
153	MINOR SMALL & LARGE BOWEL PROCEDURES AGE <70 W/O C.C.	7.3	269	16	6.5	00	3690.23	2323.38	100	00	00	00	00
411	HISTORY OF MALIGNANCY W/O ENDOSCOPY	3.9	270	16	3.6	00	2093.06	1156.59	100	00	00	00	00
455	OTHER INJURIES, POISONINGS & TOXIC EFF DX AGE <70 W/O	3.5	271	16	3.4	06	1144.41	880.29	87	00	06	00	06
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DX	2.7	272	16	9.8	12	3481.79	1692.52	50	06	31	12	00
050	SIALOADENECTOMY	3.7	273	15	4.6	06	4037.44	1188.08	100	00	00	00	00
105	CARDIAC VALVE PROCEDURE WITH PUMP & W/O CARDIAC CATH	14.9	274	15	13.0	00	26309.31	15377.56	86	06	00	06	00
151	PERITONEAL ADHESIOLYSIS AGE <70 W/O C.C.	10.1	275	15	9.6	06	5414.56	3570.98	86	00	00	00	13
227	SOFT TISSUE PROCEDURES AGE <70 W/O C.C.	3.0	276	15	3.8	00	2577.27	1209.82	93	00	00	00	06
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	5.5	277	15	8.3	13	3691.50	1572.28	66	00	20	00	13
261	BREAST PROC FOR NON-MALIG EXCEPT BIOPSY & LOC EXC	3.4	278	15	4.7	06	3434.59	1468.49	100	00	00	00	00
289	PARATHYROID PROCEDURES	6.3	279	15	8.6	13	5183.41	3232.50	100	00	00	00	00
305	KIDNEY,URETER & MAJ BLDR PROC FOR NON-MALIG AGE <70 W/	8.4	280	15	6.8	00	4732.79	3196.41	100	00	00	00	00
355	NON-RADICAL HYSTERECTOMY AGE <70 W/O C.C.	7.4	281	15	7.3	06	4291.90	2248.12	100	00	00	00	00
008	PERIPH & CRANIAL NERV & OTHER NERV SYS PROC AGE <70 W/	3.6	282	14	5.9	07	3740.65	1646.59	92	07	00	00	00
109	CARDIOTHORACIC PROCEDURES W/O PUMP	8.9	283	14	13.7	14	13654.85	11371.85	78	00	00	21	00
167	APPENDECTOMY W/O COMPLICATED PRINC DIAG AGE <70 W/O C.	5.3	284	14	5.9	07	3840.66	1511.41	100	00	00	00	00
292	OTHER ENDOCRINE, NUTRIT & METAB OR PROC AGE >70 &/OR	11.8	285	14	15.2	07	10279.07	6455.25	85	00	07	00	07
357	UTERUS & ADENEXA PROCEDURES, FOR MALIGNANCY	12.2	286	14	15.5	07	12396.57	5312.63	71	14	00	00	14
400	LYMPHOMA OR LEUKEMIA WITH MAJOR OR PROCEDURE	12.6	287	14	24.6	28	14691.76	8170.65	85	00	07	07	00
406	MYELOPROLIF DIS OR POORLY DIFF NEOPL W MAJ ORPROC & C.	12.8	288	14	7.5	00	4616.23	6609.73	92	07	00	00	00
461	OR PROC WITH DX OF OTHER CONTACT WITH HEALTH SERVICES	5.1	289	14	8.2	14	5456.13	1745.88	100	00	00	00	00
179	INFLAMMATORY BOWEL DISEASE	7.0	290	13	8.7	00	3148.29	1937.81	92	07	00	00	00
250	FX,SPRNS,STRNS & DISL OF FOREARM,HAND,FOOT AGE 70+ &/O	3.8	291	13	8.6	00	3637.70	1043.11	76	07	00	00	15
349	BENIGN PROSTATIC HYPERTROPHY AGE <70 W/O C.C.	2.9	292	13	3.3	00	1444.24	537.14	61	30	07	00	00
006	CARPAL TUNNEL RELEASE	2.3	293	12	2.6	08	2618.19	802.27	91	00	08	00	00
035	OTHER DISORDERS OF NERVOUS SYSTEM AGE <70 W/O C.C.	4.9	294	12	3.4	00	1675.34	969.22	91	08	00	00	00
044	ACUTE MAJOR EYE INFECTIONS	5.9	295	12	10.2	08	5522.47	1621.51	83	00	08	08	00
191	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES	17.9	296	12	17.5	00	18184.93	11904.73	75	00	08	16	00
196	TOTAL CHOLECYSTECTOMY WITH CDE AGE <70 W/O C.C.	10.3	297	12	11.5	00	7186.00	3727.85	91	00	00	00	08
201	OTHER HEPATOBILIARY OR PANCREAS OR PROCEDURES	8.8	298	12	11.6	08	10127.89	4993.22	66	00	00	16	16
226	SOFT TISSUE PROCEDURES AGE >=70 AND/OR C.C.	5.3	299	12	7.5	00	8161.01	3248.53	66	00	08	08	16
414	OTHR MYELOPROLIF DIS OR POORLY DIFF NEOPL DX;<70 W/O C.	5.4	300	12	4.5	00	2412.39	1514.99	66	00	00	33	00
424	OR PROCS WITH PRINCIPAL DIAGNOSIS OF MENTAL ILLNESS	14.8	301	12	21.7	08	14547.70	[illegible]07.15	66	00	16	08	08
437	SUBSTANCE DEPENDENCE, COMBINED REHAB AND DETOX. THERAP	14.6	302	12	20.3	41	8094.07	3132.94	91	08	00	00	00
009	SPINAL DISORDERS & INJURIES	8.3	303	11	10.9	09	4226.40	2446.34	81	00	00	00	18
031	CONCUSSION AGE >=70 AND/OR C.C.	3.8	304	11	3.2	00	1849.35	770.85	90	00	09	00	00
063	OTHER EAR, NOSE & THROAT OR PROCEDURES	5.0	305	11	4.1	00	3268.20	2552.29	90	00	00	09	00
169	PROCEDURES ON THE MOUTH AGE <70 W/O C.C.	3.0	306	11	3.0	00	3415.44	1141.91	90	00	00	00	09

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 STA    DE     PROF                    MIS    IPPI  OUND   ION FOR MEDICAL CARE                        RUN DATE    5/88

                                                   STATE-WIDE DRG PROFILE

                                                   01/01/88 THRU 03/31/88

  DRG                        TITLE                              GEOM RNK CASES ALOS %DAY     AVG        AVG       % DISCHARGED TO
                                                                ALOS                 OUTL   CHARGES     REIMB    HOM  TRANS  LTC  EXP OTH
  313  URETHRAL PROCEDURES, AGE 18-69 W/O C.C.                   3.6 307   11    4.1  09    2355.02     749.82  100    00    00   00  00
  373  VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES               2.8 308   11    2.0  00    1096.51     245.46  100    00    00   00  00
  440  WOUND DEBRIDEMENTS FOR INJURIES                           9.0 309   11   27.3  27   18702.52    6193.54   81    00    00   00  18
  445  MULTIPLE TRAUMA AGE 18-69 W/O C.C.                        4.0 310   11    4.6  00    1488.14     595.37  100    00    00   00  00
  038  PRIMARY IRIS PROCEDURES                                   2.4 311   10    4.2  10    3311.34     755.76  100    00    00   00  00
  047  OTHER DISORDERS OF THE EYE AGE >=18 W/O C.C.              2.5 312   10    4.1  00    1472.38     625.44   80    00    10   00  10
  117  CARDIAC PACEMAKER REPLACE & REVIS EXC PULSE GEN REPL O    4.8 313   10    3.9  00    4051.24    2793.39   90    00    10   00  00
  119  VEIN LIGATION & STRIPPING                                 5.6 314   10   14.2  10    5365.92    3088.16  100    00    00   00  00
  147  RECTAL RESECTION AGE <70 W/O C.C.                        14.0 315   10   12.8  00    9536.63    3757.63  100    00    00   00  00
  213  AMPUTATIONS FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS    12.6 316   10   10.8  00    6108.30    4060.32   70    00    10   10  10
  259  SUBTOTAL MASTECTOMY FOR MALIGNANCY AGE >=70 AND/OR C.C    4.9 317   10    7.0  10    4253.82    2125.53  100    00    00   00  00
  458  NON-EXTENSIVE BURNS WITH SKIN GRAFTS                     18.7 318   10   22.6  20   14177.55    9249.04   80    00    10   00  10

       TOTAL CASES                                                        39857   7.6  02    4695.63    2380.19   80    03    06   05  03
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Mr. Charles Shepherd, CEO
H. C. Watkins Memorial Hospital
605 South Archusa
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Dear Charles:

During the Senate hearing in Tupelo last week, you were requested to have me write a letter relative to the problems created by IRS regulations in recruiting physicians for hospitals operating as not-for-profit corporations. I am writing to you so that you may forward this information to Senator Cochran.

The general provisions of Section 501(c)(3) state that "...no part of the net earnings of the organizaton may inure to the benefit of any private shareholder or individual." The problem is the question of private inurement to physicians. It is difficult to make incentive arrangements for physicians without creating private inurement questions that cause the hospital to put its 501(c)(3) status at risk. Revenue ruling 56-185 says that payment of "excessive compensation" constitutes private inurement. It is difficult to interpret what is "excessive" in Quitman, Mississippi when you are competing for physicians that could locate in larger communities. On GCM 39498 (April 24, 1986) the Service ruled that "reasonable" compensation will not constitute private inurement. The concept of "reasonable" is difficult to define. Finally, GCM 38905 sets out five requirements relative to contingent compensation plans which severely restrict the hospital's ability to make guarantees to a physician.

To summarize, the IRS rules are written so as to require extreme care in designing a compensation package for new physicians. The cost is burdensome on a small hospital; the non-profit hospital is at a disadvantage compared to other hospitals and the risk of losing tax-exempt status because of a physician contract is an extreme penalty.

Sincerely,

Chuck

Charles E. Rea

CER:jj

Senator COCHRAN. Thank you, Charles Shepherd with an attachment for your very fine statement. You're a good help in the hearing. We appreciate your being here and helping us in this way. We'll now hear from Sonja Jenkins, who is project director of the Northeast Mississippi Rural Health Consortium.

Ms. JENKINS. Thank you, Senator Cochran, members of the staff and panel. Ladies and gentlemen, it is my pleasure to be with you this morning as a witness for the Subcommittee on Aging and also as the spokesperson for the Northeast Mississippi Rural Health Consortium.

Since the first year of this Consortium's existence, I have solicited and welcomed opportunities to speak and write about rural health care and also about what our project is doing to progressively and positively address the issues and problems surrounding our rural community hospitals.

The first newspaper article I read on the very first day I took this job was one found on the front page of the Wall Street Journal, and it was entitled, "The Closing of America's Rural Hospitals." The article painted a very grim and very discouraging portrait of our community hospitals in the United States. But rather than discouraging me, I think reading this article more or less gave my job a genuine focus and gave me a sense of mission and purpose. And in the past ten months as I've worked in our communities and the hospitals that this consortium represents, that sense of mission and purpose is constantly renewed.

My testimony in full has been submitted to the Committee, so this morning just let me highlight from these comments. First of all, our small rural hospitals are closing. Of the approximately 2,700 rural hospitals in the United States, 700 of those have closed in the past five years and as many as 600 are projected to close by 1990. Although closure may be appropriate for some, a large number of these hospitals are a vital part of the health care system in our communities. In fact, about 345 of the nation's rural hospitals are their communities' sole source of health care. It is clear that in closing these hospitals, it could significantly impede access to health care, particularly for the old and the poor. Rural residents over age 75 suffer most when a rural hospital closes because they can't travel to the next hospital for care.

In a recent study, only 18 percent of those over the age of 75 crossed a county line to get medical care, compared with 31 percent of those under 75. The lack of a hospital within a reasonable community distance or the presence of a hospital with a poor reputation substantially reduces the attractiveness of a community and retards its stability and growth. The fate of rural community hospitals will affect not only the well-being of rural residents but the ultimate survival of their communities.

I can say with pride that through the auspices of a Robert Wood Johnson Foundation grant that sixteen Northeast Mississippi hospitals will not be among those unfortunate institutions to close their doors in the next few years. These sixteen hospitals compose the Northeast Mississippi Rural Health Consortium and in the next four years will be working in a spirit of cooperation to demonstrate that with greater attention to cost efficiency and expanded revenue bases, threatened rural institutions can improve and maintain their integral role in ensuring rural Northeast Mississippians access to quality health care.

Before I tell you about our project in general, just let me mention a little bit about the Robert Wood Johnson Foundation, which, by the way, was the funding component of the Swing Bed Program back in the early 1980's here. It was established in 1936 by General Robert Wood Johnson, whose wealth was derived from the Johnson and Johnson Company. Johnson constantly explored new ways to serve humanity through medicine and when he died in 1968, he left virtually his entire estate to the Foundation, which at that time was valued at 1.2 billion dollars. Since becoming a philanthropy, the Foundation has appropriated 826.2 million dollars in order to identify new opportunities for bringing better health care to the American people.

General Johnson believed strongly in the philosophy of helping people to help themselves, and it was with this credo always in mind that the Foundation in 1987 issued a call to hospital consortia to submit proposals aimed at improving the access, quality, and cost efficiency of health services for rural populations.

Taking the initiative, North Mississippi Medical Center here in Tupelo issued an invitation to 25 Northeast Mississippi hospitals to form a cooperative alliance. Sixteen of those hospitals responded and the Consortium was organized. And fortunately in November of that year, the Consortium was awarded a $680,000 grant for four years to work within rural health care in this area.

Our aim is to improve the access, quality and cost efficiency of health services for rural citizens in Northeast Mississippi. We serve nineteen counties in Northeast Mississippi and two counties in Northwest Alabama. The exclusively rural population of the service area is approximately 549,000 people and is poorer, older, less well-educated and less fully employed than the rest of the nation.

In our proposal to the Foundation, the Consortium identified four problems within the service area. First of all, small size and rural location make it difficult for local community hospitals to obtain and retain clinical and support staff personnel which affects quality of care and reimbursement under a prospective payment system; number two, because medical staffs are mostly primary care physicians, local access to specialty care is limited; decreasing occupancy levels have created a supply of unfilled hospital beds while a state moratorium has created an un-met need for long-term care beds; and fourthly, there is a lack of focused support for and understanding of the changing role of community hospitals.

Specifically let me talk to you about what our focus is, and we are looking at four major areas in addressing some of these problems. Our first goal is in the area of staff development and our objective is to improve the quality of health care delivery to rural populations by implementing activities to improve the supply, retention and training of nurses and other allied health care personnel. A secondary objective is to improve Medicare reimbursement by providing medical record and utilization management training and consultation services to member hospitals. And because I know that you're interested in specific ways that we are addressing these problems, let me just talk to you in terms of this particular area some of the things that we're doing or plan to do.

We're in the process of developing and coordinating a traveling nursing fair. This fair will involve resource people from our Consortium and from our nursing school directors and staff in this area. The fair will be a well-planned, highly publicized program with appeal not only to students, but to other target market groups as well who perhaps would be interested in the nursing profession—men, minority groups and older women who are looking for a new or second profession. And I point this out because these last target groups are those who are more likely to remain and work in their local communities after they obtain their nursing degree and we do want to encourage that.

The fair would travel from county to county, and each hospital would serve as a host site. We have just completed an annual school counselors day for all of our Consortium area counselors, which would educate—We hope it educated and familiarized counselors on the variety and number of opportunities to be found in health care. Health care has changed so drastically even within the past two or three years that we felt that it was important that school counselors be kept abreast of these changes so that they can give accurate information to interested students. We're competing—There's competition out there for the different professions and we want to make sure that these counselors can adequately give good information to students who are professing interest in health care.

We're also looking to work within each community to establish a community-wide community-based scholarship program for interested students or outstanding students who are interested in a health career. We want to really work within the community to develop a scholarship system and work through that hospital to set up a scholarship fund with funding coming primarily from civic and service clubs and from private contributions. We would have a community-wide board of directors which would be selected to administer the fund and we would include within each scholarship that we give a stipulation that that person, upon receiving their degree, would return to their home communities and give some portion of their career service to that community and in a way thank that community for their education, for paying for their education.

As small rural hospitals adjust to the drastic changes in health care delivery, they find that their services are being utilized primarily by the elderly population. Thus, as hospitals adjust their programs and services to meet these elderly needs, our Consortium will be working with each hospital's staff to help them adjust to those changes and assist them in dealing more effectively with their elderly patients.

Our second goal is in the area of satellite specialty clinics, which we hope will improve access to specialized health care for rural populations by establishing hospital-based satellite specialty clinics in any number of specialties. This would require a specialist from a larger area, such as Tupelo, that would be interested in going out to one of the smaller hospitals in our consortium area and setting up a satellite specialty clinic.

Thirdly, our goal is an objective of facility conversion, which would enhance the revenue base of member hospitals by converting unused areas in existing facilities for such things as long-term care, personal care, respite care, adult day care centers, or congregate living arrangements. And the principal activities under this area will be to include petitioning the Mississippi Legislature for a special exemption to the current moratorium on additional long-term beds.

Already our hospitals are implementing, are expanding their Swing Bed Program not only to help stabilize and enhance the revenue base, but also to take advantage of the growing needs of swing beds and the level of care that they provide. In terms of nursing home beds, we already have two hospitals within our group which have existing facilities for extended care services but are empty because of this existing nursing home moratorium.

One highlight that Mr. John Hicks has mentioned that we are also working with is with the Aberdeen-Monroe County Hospital, and we will be providing some assistance there both programmatically and financially to this new independent living facility for the elderly that they are presently in the process of converting to. Our last objective is in the area of community awareness. We really want to assist rural populations in gaining access to health care by improving their awareness of what health care resources are available in their community and to help them develop an understanding of what the changing role of rural health care is and what it can mean to them.

We also want to develop a system of community support for the local hospital. Some of that support has been eroded and lost. We feel that that needs to be regained. We want to do this through community education forums, through civic and service club presentations, media communications, direct mail and the establishment of a Health-line in each hospital which would be a direct inquiry line to the local health. The provider would provide answers to people's questions in the community about health care.

In essence, just let me say that the Northeast Mississippi Rural Health Consortium is taking aggressive, progressive, positive steps to address many of the crisis issues in rural health care. If successful, the project will become a national demonstration model for rural health care in the United States. Our Consortium project also illustrates how rural hospitals can continue serving their communities if they collectively confront their problems.

General Robert Wood Johnson once said that to be an agent of change is to be a taker of risks, and I think that the Consortium is taking risks through this project but we are certain that those risks will certainly justify the necessary but innovative and exciting changes that must take place for our rural health systems to survive. Thank you very much for the opportunity to speak this morning.

[The prepared statement of Ms. Jenkins follows:]

NORTHEAST MISSISSIPPI RURAL HEALTH CONSORTIUM
SONJA A. JENKINS, PROJECT DIRECTOR

HEARING OF THE SENATE SUB-COMMITTEE ON AGING

Rural community hospitals play a major role in providing health services. Of the approximately 2,700 rural hospitals in the United States today, a significant number are experiencing financial distress. As many as 600 have been projected to close by 1990. Although closure may be appropriate for some, a large number of rural hospitals are a vital part of the health care system in their communities. Rural hospitals represent 47 percent of the total U.S. hospitals, and they collectively serve an area encompassing about 95 million people. In fact, about 345 of the nation's rural hospitals are their communities' sole sources of health care. It is clear that closing these hospitals could significantly impede access to health care, particularly for the old and the poor. In fact, rural residents over age 75 suffer most when a rural hospital closes because they cannot travel to the next hospital for care. In a recent study, only 18% of those over the age of 75 crossed a county line to get medical care, compared with 31% of those under 75.

A hospital is a revenue- and job-producing business. In a small community it may be second only to the school system in its contribution to employment, and, like the educational system, it provides a service that many community residents view as essential. The availability of quality hospital care is as important as educational, social and cultural opportunities in drawing businesses and individuals to a community. The lack of a hospital within a reasonable community distance, or the presence of a hospital with a poor reputation, substantially reduces the attractiveness of a community and retards its stability and growth. The fate of rural community hospitals will affect not only the well-being of rural residents but the ultimate survival of their communities.

Through the auspices of a Robert Wood Johnson Foundation grant, sixteen Northeast Mississippi hospitals will not be among those unfortunate institutions to close their doors in the next few years. These sixteen hospitals compose the Northeast Mississippi Rural Health Consortium (NMRHC) and in the next four years will be working in a spirit of cooperation to demonstrate that with greater attention to cost efficiency and expanded revenue bases, threatened rural institutions can improve and maintain their integral role in ensuring rural Northeast Mississippians access to quality health care.

Before I tell you the specifics about the project goals of the Consortium, let me first say a word or two about the Robert Wood Johnson Foundation.

This Foundation is an independent philanthropy interested in improving health care in the United States. It was established in 1936 by General Robert Wood Johnson, whose wealth was derived from the Johnson & Johnson Company. Johnson constantly explored new ways to serve humanity through medicine. When he died in 1968, he left virtually his entire estate to the Foundation which at the time was valued at 1.2 billion dollars. Since becoming a philanthropy 15 years ago, the Foundation has appropriated 826.2 million dollars in order to identify new opportunities for bringing better health and medical care to the American people.

General Johnson believed strongly in the philosophy of helping people to help themselves. With this credo always in mind, the Foundation in 1987 issued a call to hospital consortia to submit proposals aimed at improving the access, quality, and cost efficiency of health services for rural populations.

Taking the initiative, North Mississippi Medical Center, a 650-bed rural referral center in Tupelo, Mississippi, heard the call and issued an invitation to 25 Northeast Mississippi hospitals to form a cooperative alliance. Sixteen of those hospitals responded and the Northeast Mississippi Rural Health Consortium was organized. In November of 1987, the Consortium was awarded a 680,000 dollar grant for four years.

The aim of the Northeast Mississippi Rural Health Consortium is to improve the access, quality and cost-efficiency of health services for rural citizens in Northeast Mississippi. The Consortium serves nineteen counties in Northeast Mississippi and two counties in Northwest Alabama. The exclusively rural population of the service area is approximately 549,000 and is poorer, older, less well-educated, and less fully employed than the rest of the nation.

In its proposal to the Robert Wood Johnson Foundation, the Consortium identified four major problems within the service area:

(1) Small size and a rural location make it difficult for local community hospitals to obtain and retain clinical and support staff personnel, which affects quality of care and reimbursement under a prospective payment system;

(2) Because medical staffs are mostly primary care physicians, local access to specialized care is limited;

(3) Decreasing occupancy levels have created a supply of unfilled hospital beds, while a State moratorium has created an unmet need for long-term care beds;

(4) There is a lack of focused support for and understanding of the changing role of community hospitals.

Once these problems were identified, the members of the Consortium developed a proposal which would programatically address these issues. Specifically, the NMRHC project is structured for focus in four major areas:

(1) STAFF DEVELOPMENT PROGRAM -- The principal objective of the staff development program is to improve the quality of health care delivery to rural populations by implementing activities to improve the supply, retention, and training of nurses and other allied health care personnel, especially physical therapists. A secondary objective is to improve Medicare reimbursement by providing medical record and utilization management training and consultation services to member hospitals. The principal activities in staff development include career education programs, development of scholarships and grants for students in health care educational programs, developing closer ties with schools, focus groups on staff retention issues made up of key consortium personnel, and customized training programs for clinical and support staff personnel.

Traveling Nurse Fair

Specific examples include:

(A) The development and coordination of a travelling nursing fair -- This fair will involve resource people from all consortium hospitals and nursing school directors and staff in the area. The fair will be a well-planned, highly publicized program with appeal not only to students but to other target market groups as well -- men, minority groups, and older women who are looking for a new or second profession. The fair would travel from county to county and each hospital would serve as a host site.

(B) An annual school counselors day which educates and familiarizes counselors on the variety and the number of opportunities to be found in health care -- As health care changes, school counselors must be kept abreast of such change so they can give accurate information to those students interested in health careers.

(C) A community based scholarship program for outstanding students interested in pursuing a health career -- Community education is the key to developing a system of scholarships and grants for health care education. In the coming years, our goal is to work through each hospital to set up a scholarship fund with funding coming primarily from local civic and service clubs and from private contributions. A community-wide board of directors would be selected to administer the fund and to coordinate the granting of scholarships each year.

(D) As small rural hospitals adjust to the drastic changes in health care delivery, they find that their services are being utilized primarly by the elderly population. Thus, as hospitals adjust their programs and services to meet the needs of the elderly, the consortium will be working with each hospital's staff to help them adjust to the changes and to assist them in dealing more effectively with their elderly patients. This will be done through various educational and training programs.

(2) SATELLITE SPECIALTY CLINICS -- The principal objective of the satellite specialty clinics program is to improve access to specialized health care for rural populations by establishing hospital-based satellite specialty clinics in any number of specialties. The principal activities in establishing satellite specialty clinics will be a survey of member hospitals to establish needs and interests, recruitment of specialty physicians from member medical staffs, and facilitating activities (scheduling, site preparation, support staffing requirements, etc.) by project staff.

(3) FACILITY CONVERSION -- The principal objective of the Facility Conversion program is to enhance the revenue base of member hospitals by converting unused areas in existing facilities for long term care, personal care, respite care, adult day care centers, or congregate living arrangements. Other possibilities include expansion and improvement of outpatient departments and the use of vacant areas for physician office space. Principal activities in the facility conversion program include petitioning the Mississippi Legislature for a special exemption to the current moratorium on additional long-term care beds, market surveys to determine the optimum

strategy for facility conversion, employment of architectural consultants to assist in developing facility conversion plans, and a joint contract to carry out renovations. It is anticipated that matching loan funds will be used for renovation.

Already, our hospitals are implementing or expanding their swing bed programs not only to help stabilize and enhance their revenue base, but also to take advantage of the growing need of swing beds and the level of care which they provide. In terms of nursing home beds, we presently have 2 hospitals within our consortium group which have existing facilities for extended care services. There is a very real and very critical unmet need for nursing home beds in our rural areas, yet we must live under a legislative moratorium which hampers our opportunity to meet such needs.

One highlight in our facility conversion program is the conversion of a 36-bed acute care wing at the Aberdeen-Monroe County Hospital into a 12-unit independent living facility for the elderly. The facility will not only enhance the revenue base of the hospital, but will also provide new services for retired people in the area.

(4) COMMUNITY AWARENESS -- The principal objectives of the Community Awareness program are to assist rural populations in gaining access to health care by improving awareness of locally-available health care resources, to develop consumer understanding of the changing role of rural health care providers, and to develop a system of community support for the local hospital. Principal activities in the Community Awareness Program include the development of community education forums, civic club/social organization presentations, media communications, direct mail, and Healthline--a direct inquiry line to the local health care provider.

CONCLUSION -- In essence, the Northeast Mississippi Rural Health Consortium is taking aggressive, positive steps to address many of the crisis issues in rural health care. If successful, the project will become a national demonstration model for rural health care in the United States. The NMRHC project also illustrates how rural hospitals can continue serving their communities if they collectively confront their problems.

Senator COCHRAN. Thank you, Sonja Jenkins, for your excellent presentation. It's very interesting to hear about the work of the Consortium and the things that you're doing to help deal with some of the problems that are being faced by smaller towns and rural communities.

I wondered as you were talking because you are working, it seems, with the Northeast Mississippi Medical Center in the conversion of the acute care wing of the Aberdeen-Monroe County Hospital into an independent living facility for elderly citizens, the extent to which you were working with the center on other projects and what the relationship is, if any, between the Consortium and John Hicks' center here?

Ms. JENKINS. North Mississippi Medical Center is a member of the sixteen member consortium and certainly has a lot of interest in what we are doing with the project. We will be working with them very closely on a number of projects that affect not only the medical center and their affiliates, but the other members of our consortium, as well.

Senator COCHRAN. In dealing with those you're trying to recruit or acquaint at least with the opportunities of careers in health care areas, your traveling nurse fair and talking with school counselors to keep them up to date on opportunities in the industry, the health care industry, do you find that there are adequate training facilities at our community colleges or other colleges and universities or in our hospitals to train these people so they'll have the skills to come in and do the work, do those jobs?

Ms. JENKINS. Absolutely. Our training facilities are more than adequate. They provide excellent services. What our problem is, is getting students into these training facilities. There is fierce competition out there with students. I mean they are looking at so many diverse opportunities, some opportunities that perhaps will pay more money in the long run.

So what we're having to do is re-define what health careers are and make them more attractive and more appealing to young people and to other people, other target groups. We've got to show them that the need is there and that we can provide the training and that we do need them in these particular areas. But I have no problem. In fact, in this area we have a number of excellent nursing programs and other programs that work with us in helping to recruit and retain these people.

Senator COCHRAN. What do you foresee as the life of your program? You may have told us that, and I forgot it. Is it a four-year grant?

Ms. JENKINS. We have a four-year grant. We hope that the results will be so good that we can either be refunded or that we will be self-sustaining at the end of a four-year period.

Senator COCHRAN. Do you know whether there are any other similar activities going on in Mississippi with funds from the Johnson Foundation?

Ms. JENKINS. Robert Wood Johnson—In fact, I just returned from a meeting in Princeton, New Jersey, where the Foundation is located, and they seem to have really taken quite an interest in the State of Mississippi. And I've oftentimes—Sometimes as we go around the state, Mississippi is often looked down upon, but I do not get the feeling from the Robert Wood Johnson people that they're doing this.

I think they see a state that is on the move, that is interested in progress and in making this place a better place to live for its citizens. And I think they'd like to be a part of that, and I know that they have recently funded one of our statewide regional perinatal, perinatal regionalization programs. I know that they have indicated a real interest in looking at our Medicaid program and funding a study for that, very interested in what's happened in Mississippi and very aware of the leadership from this state and what that leadership is doing, both nationally and statewide.

Senator **Cochran**. Have you run into any federal policies or regulations that have impeded your efforts or prohibited you from accomplishing any of your goals?

Ms. **Jenkins**. Not in my particular goals, but, of course, anything that affects rural hospitals in terms of what these gentlemen have spoken to, some of the federal policies that might be hampering their efforts, certainly, it hampers my efforts in trying to keeps these facilities open and operational in providing better access to health care.

Senator **Cochran**. I notice, Charles Shepherd, in your testimony you mentioned a problem with—You said that small rural hospitals must be freed from burdensome IRS regulations which make physician recruitment even more difficult. When I heard you say that and I read that in your statement, I wondered what regulations are you referring to?

Mr. **Shepherd**. This has to do with the relationship which exists between a prospective physician and the hospital. In our particular case, we're a 501C3 organization. If we are to recruit physicians, we should face the facts. All too often, you don't recruit them, you buy them. And in order to buy a doctor, you pay a dear price.

You establish the relationship between the physician—the financial relationship between the physician and my hospital for "X" number of dollars a year. Let's say it's a hundred thousand dollars guaranteed. At the end of that year the income for the physician has been in excess of that one hundred thousand dollars. What happens to the excess? Does he get it? Does the hospital get it? It relates to the 501C3 status and the relationship between the doctor and the hospital and the manner, and it's an incentive program.

Senator **Cochran**. What do they do now under the regulations? Do they impute that as income to the physician?

Mr. **Shepherd**. Well, we only recently reactivated our physician recruitment programs, and as I was preparing these remarks, my accountant brought this to my attention. I have to explore this further, and I will not answer the question to you that I'm not sure.

Senator **Cochran**. Why don't you ask your accountant to give me a letter?

Mr. **Shepherd**. My accountant is in the audience if would you like to. He's ready.

Senator **Cochran**. I don't want to put anybody on the spot, but this is something that we could go back to Washington and take up with the IRS or with the Finance Committee in the Senate and see if we can get something changed. If there's an inequity, then we ought to be able to address it, I think.

Mr. **Shepherd**. Well, it's interesting that the federal government has a national health service program, and it's an incentive program, also. It helps these young men through medical school and it's a good program. They will pay certain expenses for the medical student and, in return, he goes into the rural area. We seem to feel there's an analogy between the two, but we are penalized if we use money to encourage them to come to the rural area; whereas, at the same time tax dollars are being spent to encourage the doctors to come to the rural area. It's a bit contradictory.

Senator **Cochran**. So I'll have a good piece of evidence for my presentation to the IRS or however we're going to deal with this, have the accountant give me a letter or you send me a letter that he prepares and I will include that as an exhibit to your testimony and to be made a part of our permanent hearing records so we'll have something to go on.

John, you had a comment you wanted to make on this subject.

Mr. **Hicks**. I was going to say that it's largely a private inurement issue. Our hospitals are not for profit, tax exempt charitable corporations and therefore, we cannot inure to the benefit of, in this case, a physician who is a full profit economic unit. So it's a private inurement problem.

What we'd like some relief there because a hospital may need to provide financial support or guarantees to a physician so he will established his private practice in a rural community. City and county government often provide incentives to help an industry come to the area. The local government does not have a private inurement problem, but a hospital might, and it has very much complicated the efforts to attract physicians, to rural communities.

It's not a matter of buying a physician. It is a matter of providing appropriate support to start a new business that, namely, the private practice of a physician in a community that desperately needs a physician and in many cases that I'm aware of the communities themselves are willing to help fund that initial start-up cost as are hospitals. We think that it's an appropriate role for a hospital to support. If it is a private inurement issue, the hospital could lose its tax exempt status.

Senator **Cochran**. Okay. Well, I'd like to work on that with you and see if we can't get some relief in that area.

There was one other statement that I thought I would ask a question about. In your presentation, Charles Shepherd, you said presently your hospital is developing an elderly housing project looking at ways to utilize your facilities other than the traditional health care delivery service facility that you always have been. Mississippi State University did a feasibility study that showed that this had a substantial service potential. Tell me more about that. What is your elderly housing project going to be?

Mr. **Shepherd**. The Mississippi State Feasibility Study indicated that there is a reasonable percentage of elderly 62 years of age and older that really aren't elderly but older citizens who are either widowed—they're in retirement. They have reached a point in life where they no longer wish to care for a large home. They don't care to mow the grass.

Senator **Cochran**. I don't either.

Mr. **Shepherd**. They have some health problems, dietary needs and dietary planning. Perhaps as a widow at nighttime, they need security, so what we are proposing to do is to develop on the campus of the hospital an elderly housing project which would be only perhaps 20 units initially, not a large project initially. As part of the project, we would provide one or two bedrooms independent living apartments for the elderly.

Also, as a part of that project, our hospital would offer, as an option, mowing the grass, dietary services, security, housekeeping. Any services which we offer in the hospital could be offered to these people even with a nurse to check upon them periodically in regard to their health care needs. Our security people would be available at night for those widows who feel very insecure.

We feel there is a hand-in-glove program here that fits between the small rural hospital and the elderly residents in our community. And the problem that we're confronting right now is that we thought that we had funding worked out with one of the federal programs, and we were encouraged to move forward with that program by one of the federal organizations, only to be told at the last moment we do not qualify. So we're having some funding problems at the moment.

Senator **Cochran**. Have you identified any other possible sources of funding or any other program that might help you with that?

Mr. **Shepherd**. The two programs that we have looked at has been the Farmers Home Program which, unfortunately, we got to the altar and they did not show up. We are now looking at the HUD Program. We feel that Housing and Urban Development probably has a potential program that can be helpful to us. We will pursue this. We're going to be tenacious. We feel that it's a good elderly service program. It's got tremendous potential. It's not something that we're going to allow to die on the line.

Senator **Cochran**. I'd like to work with you to help identify sources of funding for that at the federal level and if you or your board would like to contact my office, I'd be glad to work with you on that, where your applications are, what you're going to do next. And we'll be glad to kind of monitor them and communicate with the agency and let them know of our interest in the thing.

It sounds to me like a very fine idea and ought to be very helpful not only in your community but probably in many, many others throughout the state. That sounds like a very important step forward for a lot of people.

[Off-the-record discussion.]

Senator **Cochran**. We are back on the record now, and I was just going to remind everyone for the record that this is a hearing being conducted under the auspices of our Subcommittee on Aging. Senator Spark Matsunaga of Hawaii is our chairman. He's authorized that this hearing be conducted in Mississippi. One unique thing, and I'll just pass this on for your information, is that Dr. Spark Matsunaga's daughter married Dr. Kelly Segars' son over in Iuka and I happened to have the pleasure, my wife and I—Rose and I attended this wedding in Washington, and I was called upon to respond to the toast on behalf of the family of the groom and it was a wonderful occasion. And Spark Matsunaga has authorized staff to be here to help us with the arrangements and the conduct of this hearing, so we owe him a big one. He's a good friend. We work very closely together.

Jane Mapp who's here, incidentally, and is going to testify later in the hearing came to Washington to testify before our hearings on the extension and reauthorization of the Older Americans Act earlier in the one hundredth Congress. So we've been working on issues involving older citizens of our country, and we're glad we have an opportunity to bring a field hearing of our Subcommittee to Mississippi to look at health care and the issues involving health care and our elderly population.

Well, moving on, I was thinking when Clifford Johnson was testifying, talking about problems at Clarksdale with uncompensated care, that there are some who think that one way to deal with this is to mandate a national health insurance program so that rather than the federal government reimbursing hospitals and physicians for expenses of health care, that the government should require national coverage, universal coverage, be made available by all employers for all their employees and that cost-shifting, as John Hicks described it in his testimony, be done in that manner.

What would your impression be of that kind of proposal? I know you need to know a lot of other things like how much this going to cost and how many small businesses is that going to put out of business; will that increase the cost of coverage to the extent that nobody can afford it even though they're required to carry it? What are some of the practical implications of it? And I don't know that we can answer all those questions today, but that's one suggestion that is being made and there are probably others.

Do you have any suggestions for how we deal with that uncompensated care problem other than just simply requiring the federal government to make up the difference from the general treasury?

Mr. JOHNSON. In my remarks, I addressed the rural/urban difference. If that was equal, and I showed some figures there that even just on one of those issues if we had been able to get the same amount of money that the urban hospital got for the same service, our hospital would not be looking for money at this time to buy furniture or to upgrade our facility from a 1952 facility to a modern facility. To me it's just being paid for your service and not being expected to give everything away.

See, the Medicare program that came into effect in 1965 guaranteed the senior Americans health services, and these services have been guaranteed and have been added to through all these years. But yet, the reimbursement has been decreased all that time. Services to elderly have gone up. Reimbursement has gone down, and we've gotten to the point where we can't keep our facilities updated, our equipment updated.

And we just need to get paid for what we're doing. Whether it's through some kind of national health service health insurance program or what, the problem to us is getting paid for what we do. I don't know if that helps you or not.

Senator COCHRAN. It does indeed, and I think that is a problem that we have to deal with in working with HCFA and other federal agencies and with the committees of Congress that have jurisdiction over these reimbursement statutes. I think we have to make some changes to make it more equitable for the smaller hospitals. I don't think it is equitable now, and I agree with you.

John Hicks, tell me more about your recruitment plan for placing additional family practice physicians at the rural hospital or rural health center sites.

Mr. HICKS. Well, I think the major obstacle of attracting a physician to a small rural hospital is his concern looking at the environment, will the hospital be here two years from now.

So if that's his major concern, then some assurance through support of a system which says the hospital may not be here as a 50-bed in-patient acute facility, but that we are committed to having a good emergency room, a good nursing home facility, perhaps maybe 20 beds for the in-patient medical admission that a family practice physician might need. He certainly could appropriately admit his pneumonia patient, and we could make assurances that it might not be a 60-bed in-patient facility but could be 20 medical beds and to assure him that adequate lab and x-ray facilities are there for him to take care of his patients. That's what our regional systems approach would offer, and we think that's a significant advantage. And we have been successful.

Senator COCHRAN. I was going to ask, that was my follow up. Is it working?

Mr. HICKS. Well, it's working. I think hospitals have got to— We've all got to look at new ways of doing things. We helped recruit a physician to Okolona, Mississippi. The hospital there is in very dire straits. We changed our thinking here—that community's about twenty miles away—and opened our medical staff to that physician so he actually can admit some patients here. But we are supporting him with some lab and support services, so it is working.

There is a desperate shortage of family practice physicians in this state and, I believe, nationwide. There may be a physician glut in some communities, some states and in some specialty areas, but there's not a physician glut in Mississippi, particularly not of family practice physicians. That was the basis of my statement that everything we can do to support on a national scope the training, support of the training program, the family practice residencies would be very beneficial.

Senator COCHRAN. Well, I made myself a note during the testimony of this panel looking into the possibility of introducing legislation to establish an assistance program for training family physicians, and I don't know whether that should be a part of the national health service training programs or how we might look into it. But I do intend to research that when we get back and see what the likelihood is, the need of, the feasibility of a program of that kind is. Do any of you have any reaction as to that?

Mr. HICKS. For continuing the support of the National Health Corps Program, which has helped attract physicians into many of our communities.

Mr. JOHNSON. We probably need to change the requirements because we have a number of—We don't qualify at this time for Health Service Corps in Clarksdale because we have—They say we have too many primary care physicians, but yet they're out stacked over here on one side in internal medicine. And we need pediatricians very badly, and we can't qualify to get them. They could supply us with pediatricians if we could qualify. We can't because of the way the staff is situated.

Mr. **Shepherd**. We do have a National Health Service Corps physician on our staff in our county, and he is providing health care for a segment of our population that perhaps otherwise would not be able to get health care.

But the problems you run into is the fact that those patients so often can't afford hospital care when they need it. We can provide the office care and, of course, we have not refused to take those people into our facility for treatment. But the bottom line is they really can't afford to pay for hospital care.

So while they're getting the care they need, it only creates an uncompensated care burden upon the local hospital, which we referred to earlier. Nonetheless, I feel that the National Health Service Program is perhaps a very good possibility for helping relieve the problem of physicians but not totally eliminate it.

Senator **Cochran**. Well, thank you very much. This has been an excellent panel. I think we're off to a good start in our hearing today. We'll take a break now for lunch and reconvene the hearing at 1:30. We stand in recess.

[Whereupon, a lunch break was taken.]

Senator **Cochran**. If our hearing could come to order, we will continue our panels of witnesses. Our panel now will consist of Dr. Edward Hill, who is a private physician in Hollandale, Mississippi; Richard Russell, who is a physician in New Albany. He's chief of staff at the Union County General Hospital. Thad Bridges is executive director of the Vicksburg-Warren Community Health Center in Vicksburg, Mississippi. Jane Mapp is area agency director at Three Rivers Planning and Development District in Pontotoc. Ames Tyron is a physician, executive director of the Geriatric Center at the University of Mississippi Medical Center in Jackson.

We're glad to have all of you here and if we could, we'll begin with Ed Hill. We have a statement from Dr. Hill which will be made a part of the record at this point, and we ask you to make any summary comments that you would like to at this point. Dr. Hill, thank you for being here.

STATEMENTS OF J. EDWARD HILL, M.D., PRIVATE PHYSICIAN, HOLLANDALE, MS; RICHARD RUSSELL, M.D., CHIEF OF STAFF, UNION COUNTY GENERAL HOSPITAL, NEW ALBANY, MS; THAD BRIDGES, EXECUTIVE DIRECTOR, VICKSBURG-WARREN COMMUNITY HEALTH CENTER, VICKSBURG, MS; JANE MAPP, AREA AGENCY DIRECTOR, THREE RIVERS PLANNING AND DEVELOPMENT DISTRICT, PONTOTOC, MS; AND AMES TYRON, D.D.S., PH.D., EXECUTIVE DIRECTOR, GERIATRIC CENTER, UNIVERSITY OF MISSISSIPPI MEDICAL CENTER, JACKSON, MS

Dr. **Hill**. Thank you, Senator Cochran. It's a pleasure to be asked as a country family doctor to come and hear how badly we're needed. We like to hear that. We've always known that. Mr. Shepherd said he had an accountant and probably his lawyer in the audience. We'll know we've solved the manpower problem when everybody's got their family doctor in the audience. That's really what we're after. A great and urgent need exists, not for short-term solutions, but for definitive, comprehensive and long-term strategies to impact on access to and the quality of care, health care in Mississippi. Access to care, as far as I'm concerned, is the over-riding and predominant issue and is dependent upon a lot of things including health manpower recruitment and retention, health provider education, quality issues in the delivery of health care, equity in reimbursement to health care providers, the liability climate and tort reform initiatives, and, of course, the economic development of a mostly rural state. So access is limited mainly by economic reality.

I would like to briefly touch on several areas that I think would improve access for our citizens who are elderly and also who are either under insured or uninsured or are in the class of the working indigent. Some of these areas have been covered, and I won't touch on those that have been thoroughly. Health manpower I will talk about; rural hospital survival, I'll very briefly mention since it's been well-addressed; long-term care for the elderly has got great needs; Medicaid changes we've heard a little bit about; and then the uninsured, under insured and the working medically indigent; and also, I'll touch on a private sector program for the Medicare indigent in Mississippi presently.

I think it's well recognized now that primary care especially, specifically family physicians, adequately can handle somewhere between 80 and 90 percent of every health problem that walks into a health care facility. Now, the most exciting potential long-term solution to all these health care problems is the establishment of teams of health care professionals, particularly in rural areas, that provide this broad range of care. And I'll give you an example of one of those that's not in my testimony in a minute.

I understand there's federal legislation aimed at a potential solution, and I also know that the American Academy of Family Physicians has committed itself to a very extensive, very expensive and very dynamic approach to the solution of the access problems by promoting family practice residency, teaching and training, particularly in rural areas, and promoting this to students in pre-med years and in medical school. Also, the American Academy of Family Physicians in conjunction with the National Rural Health Association and with the American Hospital Association's section on small and rural hospitals is developing a monograph on recruitment and retention of family physicians in under-served areas and this ought to be available January of 1989. And I will be sure that Subcommittee receives a copy of this. Also there's a core curriculum guideline in development right now for the use in residency programs in family medicine.

Of particular importance is the fact that family practice residents will be taught to utilize the team approach, that is the health care team approach, to provide care in under-served areas and to the elderly and indigent. I think federal funding for this type of educational program would continue to experience fewer cutbacks than funding for other health education.

Also, there is badly needed some kind of financial and tax incentive enticement to promote primary care specialists in rural practices. This has been touched on by others. More equitable payment to practitioners in rural areas is long overdue, and I think this will be addressed also by others later.

An increase in this type of care in the rural regions would be the most cost effective and probably of equal or even higher quality than they receive in the urban areas. The National Health Service Corps, as was mentioned earlier in some testimony, in my estimation is not the answer. What we need is family doctors who are willing to live in communities, raise their families in communities, and be a permanent part of communities. And I don't think that we can show that that type of National Health Service Corps has been able to accomplish that.

Also, the answer is not buying physicians as somebody said because sometimes you get less than what you pay for, often, in fact, and I think some administrators can probably tell us some stories about that. I will make a statement that I like to make and that's this. It's my quote. Family physicians that are well-trained or primary care physicians who are well-trained, if you will, will be the salvation of quality cost effective medicine in America. There's no doubt in my mind and from what I can hear today in others' minds about that being a fact.

I want to give you an example, a personal example, but an example of a cooperative effort between family physicians who decide to move to a rural area and address a social and health care problem and successfully address that problem because those family physicians or primary care practitioners moved into that rural area. In 1968 through 1970, and Dr. Cobb can correct my statistics if they're wrong, but the area of Washington-Bolivar County was the highest fetal mortality rate I think in the country at that time.

During the year 1970, a program was started by family physicians in that area to do something about the access to care for the indigent and for the pregnant indigent people. Over about a three-year period of time and up for thirteen years since then the fetal mortality rate in that small area, which was the southern part of Washington County, northern part of Sharkey County, was reduced to below the national average and remained there.

Now, this program folded because of, again, a financial dilemma shortly after thirteen years in operation, mainly because of liability climate, which I will not get into at all in this hearing, but is a real problem and also to the fact that payment for delivery service was not as adequate as it should have been.

But regardless of that, this is an example of what I'm talking about putting family doctors in the small communities. They'll identify social and medical problems and probably be able to solve them better than anybody else and probably in a more cost effective way.

Now, the other thing that I want to touch on about family medicine and why I think federally it's so important that these programs are funded fully and adequately and even more so than they are now is that community hospital based family practice residency programs will go a long way in solving all these rural health manpower problems. I, along with some others in this room, believe that we probably should have residency programs in areas like—in cities like Tupelo, like Greenville, like Pascagoula, like Hattiesburg. We certainly have the medical community to support those things. We need funding to support them.

Rural hospital viability has been touched on more than adequately. I would just like to briefly touch on a more, what I consider some examples of the big obstruction to the viability of these facilities and it's been touched on. But I've got some even better figures than were given previously, I think. I'm going to give you some examples.

A representative of one state bordering us in recent testimony before the American Medical Association Reference Committee stated that Medicare reimbursement to the urban hospital for DRG 89, which is pneumonia, was $5,300, but this system only reimbursed the rural hospitals for the same DRG $2,200, a 241 percent differential. Similarly, urban hospitals received $4,400 for patients in DRG 127, that's heart failure and shock, and the rural hospital received $1,900 for such patients, a 237 percent differential.

Changes in these inequities alone would ensure the survival of most of these facilities that are needed. It would also be quite prudent to look at the marked increase in the cost of care to these patients in the urban centers if and when there were no rural hospitals. Remember that DRG payment would really go up when that person had to travel twenty miles to the urban center or thirty miles to the urban center to be treated for the same DRG.

I envision a function of the community and small rural hospital facility in the future as being one of a focal point for the wellness centers, for nursing home care, adult care, respite care, that sort of the thing. It appears to me that the community hospital would be much more cost effective and compassionate in its care of the elderly and infirmed.

What about financing long-term care? There's increasing concern how to best finance this growing expense of long-term care. The concern has been accentuated by the fact that persons over 65 represent the fastest growing segment of our population and that this group is at the highest risk of incurring chronic illness or disability. This unprecedented growth in the older population, particularly the 75 plus age group, will have a major impact on the nation's health care system.

Given the increased pressures for the development of adequate mechanisms for financing long-term care and the fiscal restraints being imposed on the public sector, the private sector will have to develop financing mechanisms in the future. In general, private sector initiatives for financing long-term care will need legislative support. Indemnity insurance plans, managed care approaches, cash accumulation plans, family support plans are some of the areas that should be explored and expanded.

Medicaid expansion for the State of Mississippi has been touched on also today. The final report of the health policy agenda for the American people which was the initiative that was put together with the cooperation of 425 representatives from different health-related, business, government and consumer groups highly recommended uniformed national standards for eligibility and benefit standards for Medicaid recipients. It was also recommended that Medicaid programs be expanded to the medically needy who are currently ineligible.

In our state in recent years, an executive level panel has recommended the expansion of Medicaid to its maximum. The recommendation was very clear in that this would be the most immediate and long-lasting economic benefit concerning health care for citizens of our state.

Now, the economic shot in the arm for the State of Mississippi by expanding Medicaid to its maximum would mean after matching formulas and multiplying factors were applied to the funds, that our economy would receive over a half billion dollars. Along with that expansion of Medicaid would come the expanding of eligibility, which would reduce significantly the number of uninsured residents of our state, many of whom would be elderly.

What about health care coverage? Initiatives have been developed or are in the process of being developed in several states for increasing health care coverage for the under-insured and uninsured. These ideas include state risk pools that subsidize health insurance premiums for small employers and individuals, mandatory employer health insurance, which was touched on briefly, and ideas like tax credit plans to encourage small employers to voluntarily provide health premium coverage. I will briefly touch on only one of these initiatives in a single state as an example.

The State of Missouri will be voting next month on a very innovative initiative for uninsured care. This initiative will expand the Medicaid program, thereby boosting their economy through matching funds. It will create an insurance pool for catastrophic coverage available to anyone, not just the elderly. It will provide insurance to people turned away because of pre-existing conditions like cancer and AIDS. It will increase Medicaid reimbursement for hospitals, physicians, pharmacies and other providers, and it will provide insurance plans for those who do not qualify for Medicaid or who were within 150 percent of the federal poverty level.

Premiums will be based on income and will be funded by an earning tax, which will be six-tenths percent for all employers. Corporations who do not have health insurance on their employees will make a similar tax on net profits.

Regardless of your philosophical feeling about this type of subsidy, reality dictates that we look at this very carefully and develop programs that would be unique for our own state. It is very likely that successful programs might require national legislative help or changes or improvement.

Let me give you an example of a plan that might be considered in a poor state like Mississippi utilizing the Medicaid program, and this would require some legislative changes in order to be able to do that, but suppose every county in the State of Mississippi were required to contribute to a pool. Suppose that every hospital were required to contribute a risk pool and suppose that, heaven forbid, there were a tax of some kind, small, to contribute to that pool. Then for a minimum price, what it would cost to take care of a recipient, an employer would be able to purchase Medicaid coverage for his employees and family.

One state has looked into this. It's not been done, but a state in the South, and that cost would be five hundred dollars a year for the family and employer, which is an awful inexpensive health insurance. Now, perhaps this would cover people like agricultural workers, for example, who have no coverage at all in this state now, and certainly congressional action would have to take place in order for the Medicaid program to be utilized in such a manner.

The last thing I'd like to touch on is an initiative in which the Mississippi State Medical Association has developed and implemented, a program called the Senior Care Program. The Senior Care Program is developed with the Councils on Aging in every county—will be in every county of Mississippi—and what it will do is the Councils on Aging will certify an elderly, indigent Medicare recipient as being at a certain level of income or below and will certify that person as being an indigent Medicare recipient.

That program would also identify the physicians in the state who are willing to accept assignment on all of those patients. The recipient will have a card which he will present to the physician. The physician will see them on assignment, and we hope that the physicians will not push for payment of the 20 percent co-insurance or deductible, and we have strong feelings that they won't push for it. We hope that we could convince the Health Care Financing Agency to waive the 20 percent co-insurance a year deductible, but congressional persuasion might also have to be used to make that occur. Right now we're piloting this program in the Golden Triangle area, the North Delta area, and the Jones County area, and soon we plan to go statewide.

In closing, I would like to emphasize the fact that solutions to these problems will come about by the cooperation of public and private advocates. We must have tenacious advocacy for our citizens as far as health care is concerned. We must have private and government agencies committed to solving these problems, and we must have those willing to make selfless sacrifices in order to accomplish these ends. The question is not whether we can afford to make these adjustments in taking care of this significant health care problem, but the question is can we afford not to? Thank you.

[The prepared statement of Dr. Hill follows:]

ACCESS TO QUALITY CARE FOR ALL MISSISSIPPIANS -- THE FUTURE

PRESENTED TO SUBCOMMITTEE ON AGING

OF

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

ACCESS TO QUALITY CARE FOR ALL MISSISSIPPIANS -- THE FUTURE

A GREAT AND URGENT NEED EXISTS, NOT FOR SHORT TERM SOLUTIONS, BUT FOR DEFINITIVE, COMPREHENSIVE, AND LONG-TERM STRATEGIES TO IMPACT ON ACCESS TO AND THE QUALITY OF HEALTH CARE IN MISSISSIPPI. ACCESS TO CARE IS THE OVER-RIDING AND PREDOMINANT ISSUE, AND IS DEPENDENT ON MANY FACTORS, INCLUDING HEALTH MANPOWER RECRUITMENT AND RETENTION, HEALTH PROVIDER EDUCATION, QUALITY ISSUES IN DELIVERY OF HEALTH CARE, EQUITY IN REIMBURSEMENT TO HEALTH CARE PROVIDERS, THE LIABILITY CLIMATE AND TORT REFORM INITIATIVES, AND THE GENERAL ECONOMIC DEVELOPMENT OF A MOSTLY RURAL STATE. ACCESS IS LIMITED MAINLY BY ECONOMIC REALITY.

I WOULD LIKE TO, AS BRIEFLY AS POSSIBLE, TOUCH ON SEVERAL AREAS THAT I THINK WOULD IMPROVE ACCESS TO QUALITY CARE FOR OUR CITIZENS WHO ARE ELDERLY AND EITHER UNDER INSURED, UNINSURED, OR ARE IN THE CLASS OF WORKING INDIGENT. THE AREAS I WILL COVER WILL INCLUDE: a. HEALTH MANPOWER NEEDS, b. RURAL HOSPITAL SURVIVAL, c. LONG-TERM CARE FOR ELDERLY, d. MEDICAID CHANGES, e. THE UNINSURED, UNDER INSURED AND WORKING MEDICALLY INDIGENT, f. A PRIVATE SECTOR PROGRAM FOR THE MEDICARE INDIGENT.

IMPROVING HEALTH MANPOWER IN RURAL AREAS

I THINK IT IS WELL RECOGNIZED BY NOW, THAT PRIMARY CARE SPECIALISTS CAN ADEQUATELY HANDLE SOMEWHERE BETWEEN 80 TO 90 PERCENT OF ALL PROBLEMS THAT PRESENT TO THE GENERAL HEALTH CARE FACILITY. THE MOST EXCITING POTENTIAL LONG-TERM SOLUTION TO ALL OF THESE HEALTH CARE PROBLEMS IS THE ESTABLISHMENT OF TEAMS OF HEALTH CARE PROFESSIONALS, PARTICULARLY IN RURAL AREAS, THAT PROVIDE A BROAD RANGE OF CARE. I UNDERSTAND THERE IS FEDERAL LEGISLATION AIMED AT THIS POTENTIAL SOLUTION AND I ALSO KNOW THAT THE AMERICAN ACADEMY OF FAMILY PHYSICIANS HAS COMMITTED ITSELF TO A VERY INTENSIVE AND VERY DYNAMIC APPROACH TO THE SOLUTION OF THE ACCESS PROBLEMS, BY PROMOTING FAMILY PRACTICE, PARTICULARY IN RURAL AREAS, TO STUDENTS. THE AMERICAN ACADEMY OF FAMILY PHYSICIANS IN CONJUNCTION WITH THE NATIONAL RURAL HEALTH ASSOCIATION AND THE AMERICAN HOSPITAL ASSOCIATIONS SECTION ON SMALL AND RURAL HOSPITAL IS DEVELOPING A MONOGRAPH ON RECRUITMENT AND RETENTION OF FAMILY PHYSICIANS IN UNDER-SERVED AREAS. ALSO A CORE CURRICULUM GUIDELINE IS IN DEVELOPMENT FOR THE USE IN FAMILY PRACTICE RESIDENCY PROGRAMS. OF PARTICULAR IMPORTANCE IS THE FACT THAT FAMILY PRACTICE RESIDENTS WILL BE TAUGHT TO UTILIZE THE TEAM APPROACH (THAT IS THE HEALTH CARE TEAM) TO PROVIDE CARE IN UNDER-SERVED AREAS AND TO THE ELDERLY AND INDIGENT. I THINK FEDERAL FUNDING FOR THIS TYPE OF EDUCATIONAL PROGRAM WOULD CONTINUE TO EXPERIENCE FEWER CUTBACKS THAN FUNDING FOR OTHER EDUCATION. ALSO, THERE IS BADLY NEEDED SOME KIND OF FINANCIAL AND TAX INCENTIVE ENTICEMENT TO PROMOTE

PRIMARY CARE SPECIALIST IN RURAL PRACTICES. MORE EQUITABLE PAYMENT TO PRACTICIONERS IN RURAL AREAS IS LONG OVERDUE. AN INCREASE IN THIS TYPE OF CARE IN THE RURAL REGIONS WOULD BE MORE COST EFFECTIVE AND PROBABLY OF EQUAL TO HIGHER QUALITY MEDICAL CARE.

RURAL HOSPITAL VIABILITY -- HOSPITAL ACCESSIBILITY

MULIPLE FACTORS ARE HAVING AN IMPACT ON THE VIABILITY OF THE SMALL AND RURAL HOSPITALS. WITH THE AGING OF OUR POPULATION, IT IS VERY LIKELY THAT THE SMALL COMMUNITY AND/OR RURAL HOSPITAL COULD BE THE FOCAL POINT FOR DELIVERY OF HEALTH CARE TO THE ELDERLY IN THE FUTURE. THE FACTORS THAT ARE HAVING AN ADVERSE EFFECT INCLUDE A SMALL POPULATION AND TAX BASE AND DELIVERY OF AN INCREASED AMOUNT OF UNCOMPENSATED CARE. OTHER FACTORS THAT HAVE AN EFFECT ON THE FINANCIAL VIABILITY OF THESE HOSPITALS INCLUDE MEDICARE AND MEDICAID REIMBURSEMENT POLICIES, INCREASED COMPETITION IN THE DELIVERY OF HEALTH CARE SERVICES, AND LEGISLATIVELY MANDATED LIMITS ON THE INOVATIONS BY THE STAFFS, AND ADMINISTRATION OF THESE HOSPITALS. I WILL BRIEFLY TOUCH ON THE MORE URGENT OBSTRUCTIONS TO THE VIABILITY OF THESE FACILITIES. IN MY OPINION, THE SINGLE MOST IMPORTANT ASPECT OF FINANCIAL SURVIVAL OF THE SMALL RURAL HOSPITAL IS THE URBAN/RURAL DIFFERENTIAL IN PAYMENTS BY MEDICARE'S PROSPECTIVE PRICING SYSTEM. AN URBAN/RURAL DIFFERENTIAL WAS INCORPORATED INTO THE PROSPECTIVE

PAYMENT SYSTEM PAYMENT RATES TO ACCOUNT FOR LABOR AND NON-LABOR COST DIFFERENCES IN URBAN AND RURAL HOSPITALS. ON AVERAGE, THIS RESULTS IN FEDERAL PAYMENTS TO RURAL HOSPITALS BEING 9 TO 27% LESS THAN SUCH PAYMENTS TO URBAN HOSPITALS. FOR EXAMPLE, A REPRESENTATIVE OF ONE STATE IN RECENT TESTIMONU BEFORE AN AMERICAN MEDICAL ASSOCIATION REFERENCE COMMITTEE STATES THAT, MEDICARE REIMBURSES THE URBAN HOSPITALS $5,300 FOR PATIENTS IN DRG 89 (PNEUMONIA), BUT ONLY REIMBURSES RURAL HOSPITALS $2,200 FOR THE PATIENT IN THIS DRG. A 241% DIFFERENTIAL. SIMILARLY, URBAN HOSPITALS RECEIVE $4,500 FOR PATIENTS IN DRG 127 (HEART FAILURE AND SHOCK) WHILE RURAL HOSPITALS ONLY RECEIVE $1,900 FOR SUCH PATIENTS, A 237% DIFFERENTIAL. CHANGES IN THESE INEQUITIES ALONE WOULD INSURE THE SURVIVAL OF MOST OF THESE FACILITIES THAT ARE NEEDED. IT WOULD ALSO BE QUITE PRUDENT, TO LOOKED AT THE MARKED INCREASE IN THE COST OF CARE FOR PATIENTS IN THE URBAN CENTERS IF AND WHEN THE RURAL HOSPITALS CLOSE. I INVISION THE FUNCTION OF THE COMMUNITY AND SMALL RURAL FACILITIES IN THE FUTURE BEING ONE OF A FOCAL POINT FOR WELLNESS CENTERS, NURSING HOME CARE, ADULT DAY CARE, AND RESPITE CARE. IT APPEARS TO ME THAT THIS WOULD BE MUCH MORE COST EFFECTIVE AND COMPASSIONATE MANNER IN WHICH TO TAKE CARE OF THOSE ELDERLY AND INFIRMED WHO MUST BE INSTITUTIONALIZED.

FINANCING LONG-TERM CARE

THERE IS INCREASING CONCERN OVER HOW TO BEST FINANCE THE GROWING EXPENSES OF LONG-TERM CARE. THIS CONCERN HAS BEEN ACCENTUATED BY THE FACT THAT PERSONS OVER 65 REPRESENT THE FASTEST GROWING SEGMENT OF OUR POPULATION, AND THAT THIS GROUP IS AT THE HIGHEST RISK OF INCURRING CHRONIC ILLNESS OR DISABILITY. THIS UNPRECENDENTED GROWTH IN THE OLDER POPULATION -- PARTICULARLY THE 75 PLUS AGE GROUP -- HAVE A MAJOR IMPACT ON THE NATION"S HEALTH CARE SYSTEM. GIVEN THE INCREASED PRESSURES FOR THE DEVELOPMENT OF ADEQUATE MECHANISMS FOR FINANCING LONG-TERM CARE AND THE FISCAL RESTRAINTS BEING IMPOSED ON THE PUBLIC SECTOR, THE PRIVATE SECTOR WILL HAVE TO DEVELOP FINANCING MECHANISMS IN THE FUTURE. IN GENERAL, PRIVATE SECTOR INITIATIVES FOR FINANCING LONG-TERM CARE WILL NEED LEGISLATIVE SUPPORT. INDEMNITY INSURANCE PLANS, MANAGED CARE APPROACHES, CASH ACCUMULATION PLAN, AND FAMILY SUPPORT PLANS ARE SOME OF THE AREAS THAT MUST BE EXPLORED AND EXPANDED.

MEDICAID EXPANSION

THE FINAL REPORT OF HEALTH POLICY AGENDA FOR THE AMERICAN PEOPLE, AN INITIATIVE THAT WAS PUT TOGETHER WITH THE COOPERATION OF 425 REPRESENTATIVES FROM DIFFERENT HEALTH RELATED, BUSINESS, GOVERNMENT, AND CONSUMER GROUPS, HIGHLY RECOMMENDED UNIFORM NATIONAL STANDARDS FOR MEDICAID ELIGIBILITY BENEFITS. IT WAS ALSO RECOMMENDED THAT MEDICAID PROGRAMS BE EXPANDED TO THE MEDICALLY NEEDY WHO ARE CURRENTLY ELIGIBLE.

IN OUR STATE, IN RECENT YEARS, AN EXECUTIVE LEVEL COMMITTEE HAS RECOMMENDED THE EXPANSION OF THE MEDICAID PROGRAM TO ITS MAXIMUM. THE RECOMMENDATION WAS VERY CLEAR IN THAT THIS WOULD BE THE MOST IMMEDIATE AND LONG LASTING ECONOMIC BENEFIT CONCERNING HEALTH CARE FOR CITIZENS OF OUR STATE. THE ECONOMIC SHOT IN THE ARM FOR THE STATE OF MISSISSIPPI BY EXPANDING MEDICAID TO ITS MAXIMUM WOULD MEAN, AFTER MATCHING FORMULAS AND MULTIPLYING FACTORS WERE APPLIED TO THE FUNDS, THAT OUR ECONOMY WOULD RECEIVE OVER A HALF BILLION DOLLARS. ALONG WITH THAT EXPANSION OF MEDICAID WOULD COME THE EXPANDING OF ELIGIBILITY WHICH WOULD REDUCE SIGNIFICANTLY THE NUMBER OF UNINSURED RESIDENTS OF OUR STATE.

INITIATIVES FOR INCREASING HEALTH CARE COVERAGE

INITIATIVES HAVE BEEN DEVELOPED OR ARE IN THE PROCESS OF BEING DEVELOPED IN SEVERAL STATES FOR INCREASING HEALTH INSURANCE COVERAGE FOR THE UNDER-INSURED AND UNINSURED. THESE IDEAS INCLUDE STATE RISK POOLS THAT SUBSIDIZE HEALTH INSURANCE PREMIUMS FOR SMALL EMPLOYERS AND INDIVIDUALS, MANDATORY EMPLOYER HEALTH INSURANCE LEGISLATION, AND IDEAS LIKE TAX CREDIT PLANS TO ENCOURAGE SMALL EMPLOYERS TO VOLUNTARILY PROVIDE HEALTH PREMIUM COVERAGE. I WILL BRIEFLY TOUCH ON ONLY ONE OF THOSE INITIATIVES IN A SINGLE STATE. THE STATE OF MISSOURI WILL BE VOTING ON A VERY INNOVATIVE INITIATIVE FOR UNINSURED CARE. THIS INITIATIVE WILL EXPAND THE MEDICAID PROGRAM THEREBY BOOSTING THEIR ECONOMY THROUGH MATCHING FUNDS; IT WILL CREATE AN INSURANCE POOL FOR CATESTROPHIC COVERAGE AVAILABLE FOR ANYONE; IT WILL PROVIDE INSURANCE TO PEOPLE TURNED AWAY BECAUSE

OF PRE-EXISTING CONDITIONS(THAT IS CANCER OR AIDS); IT WILL INCREASE MEDICAID REIMBURSEMENT FOR HOSPITALS, PHYSICIANS, PHARMACIES AND OTHER PROVIDERS; AND IT WILL PROVIDE INSURANCE PLANS FOR THOSE WHO DO NOT QUALIFY FOR MEDICAID AND WHO ARE WITHIN A 150% OF THE FEDERAL POVERTY LEVEL. PREMIUMS WILL BE BASED ON INCOME. THIS INITIATIVE IN MISSOURI WILL BE FUNDED BY AN EARNING TAX WHICH WILL BE 0.6% FOR ALL EMPLOYERS. CORPORATIONS THAT DO NOT OFFER HEALTH INSURANCE WILL PAY A SIMILAR TAX ON NET PROFITS.

THERE ARE INNUMERABLE OTHER PLANS INCLUDING MULTI-EMPLOYEE TRUSTS AND GROUP ARRANGEMENTS, ARRANGEMENTS SUBSIDIZING PREMIUMS FOR EMPLOYERS WITH LESS THAN 20 EMPLOYEES AND ALSO OTHER SUBSIDITIES WITH LESS THAN 100 EMPLOYEES AND PLANS TO HELP THOSE PHYSICALLY DISABLED THAT ARE WORKING OR WANT TO WORK BUT NEED INSURANCE COVERAGE TO PAY FOR PHYSICAL THERAPY, PERSONAL CARE ATTENDANTS, WHEELCHAIR REPAIR, ETC.

REGARDLESS OF YOUR PHILOSOPHICAL FEELING ABOUT THIS TYPE OF SUBSIDY, REALITY DICTATES THAT WE LOOK AT THIS VERY CAREFULLY AND DEVELOP PROGRAMS THAT WOULD BE UNIQUE FOR OUR OWN STATE. IT IS VERY LIKELY THAT SUCCESSFUL PROGRAMS MIGHT REQUIRE NATIONAL LEGISLATIVE HELP, CHANGES, OR APPROVAL. TO GIVE YOU AN EXAMPLE OF A PLAN THAT MIGHT REQUIRE CONGRESSIONAL ACTION LET ME OUTLINE THIS EXAMPLE. SUPPOSE THAT EVERY COUNTY IN THE STATE OF MISSISSIPPI WERE TO PLACE A CERTAIN AMOUNT OF MONEY INTO A RISK POOL. SUPPOSE THAT EACH HOSPITAL IN THE STATE WERE REQUIRED TO

CONTRIBUTE TO THIS RISK POOL AND THAT EVEN THERE WAS A SMALL EARNING TAX THAT WENT INTO THE POOL. THEN LET'S SUPPOSE THAT EMPLOYERS, FOR A MINIMUM PURCHASE PRICE COULD BUY MEDICAID COVERAGE FOR THEIR EMPLOYEES. PERHAPS THEY COULD PURCHASE A HEALTH CARE COVERAGE AT A MUCH LOWER RATE THAN TRADITIONAL HEALTH INSURANCE COVERAGE THEREBY INSURING A LARGE SEGMENT OF EMPLOYEES THAT HERE-TO-FORE HAVE NOT HAD ANY KIND OF COVERAGE. PERHAPS AGRICULTURAL WORKERS WOULD BE A GOOD EXAMPLE OF THOSE THAT COULD BE COVERED AND MAY NOT HAVE COVERAGE NOW. CERTAINLY, CONGRESSIONAL ACTION WOULD HAVE TO TAKE PLACE IN ORDER FOR THE PROGRAM TO BE UTILIZED IN SUCH A MANNER.

MISSISSIPPI STATE MEDICAL ASSOCIATION SENIOR CARE PLAN

IN OUR STATE, THE MISSISSIPPI STATE MEDICAL ASSOCIATION HAS DEVELOPED AND IS IMPLEMENTING A PROGRAM CALLED THE SENIOR CARE PROGRAM. THE SENIOR CARE PROGRAM WAS DEVELOPED IN CONJUNCTION WITH THE MISSISSIPPI COUNCIL ON AGING AND THE MISSISSIPPI STATE MEDICAL ASSOCIATION TO ENABLE LOW INCOME MEDICARE RECEIPIENTS TO IDENTIFY PHYSICIANS WHO WILL BE WILLING TO ACCEPT MEDICARE ASSIGNMENTS. SENIOR CARE IS NOW OPERATING THROUGH LOCAL COUNCILS ON AGING AND THE MSMA. THE PROGRAM IS FOR LOW INCOME OLDER PERSONS AND MISSISSIPPI PHYSICIANS WHO WILL ACCEPT MEDICARE ASSIGNMENT UPON PRESENTATION OF THE SENIOR CARE CARD. EVEN THOUGH THE 20% CO-INSURANCE AND THE YEARLY DEDUCTIBLE FOR MEDICARE PATIENTS WILL STILL EXIST, PHYSICIAN MEMBERS OF THIS PROGRAM WILL VERY UNLIKELY PUSH FOR PAYMENT OF THE CO-INSURANCE AND DEDUCTIBLE.

IT IS OUR HOPE THAT THE 20% CO-INSURANCE AND YEARLY DEDUCTIBLE WILL BE ALLOWED TO BE WAIVED BY THE HEALTH CARE FINANCING AGENCY. CONGRESSIONAL PERSUASION MIGHT ALSO BE OF BENEFIT IN HAVING THIS REQUIREMENT WAIVED FOR THE MEDICARE POOR. THIS PROGRAM IS PRESENTLY BEING PILOTED IN THE GOLDEN TRIANGLE AREA, THE NORTH DELTA AREA, THE JONES COUNTY AREA OF MISSISSIPPI AND WILL SOON GO STATEWIDE.

IN CLOSING, I WOULD LIKE TO EMPHASIZE THE FACT THAT SOLUTIONS TO THESE PROBLEMS WILL COME ABOUT BY THE COOPERATION OF PUBLIC AND PRIVATE ADVOCATES. WE MUST HAVE TENACIOUS ADVOCACY FOR OUR CITIZENS AS FAR AS HEALTH CARE IS CONCERNED. WE MUST HAVE PRIVATE AND GOVERNMENT AGENCIES COMMITTED TO SOLVING THESE PROBLEMS AND WE MUST HAVE THOSE WILLING TO MAKE SELFLESS SACRIFICES IN ORDER TO ACCOMPLISH THESE ENDS. THE QUESTION IS NOT WHETHER WE CAN AFFORD TO MAKE THESE ADJUSTMENTS IN TAKING CARE OF THIS SIGNIFICANT HEALTH CARE PROBLEM, BUT THE QUESTION IS CAN WE AFFORD NOT TO?

Senator Cochran. Thank you very much, Dr. Hill, for your excellent presentation, some interesting ideas and very good observations, I think.

Dr. Richard Russell is our next witness, chief of staff of Union County General Hospital.

Dr. Russell. Senator Cochran, when I introduced you at Pontotoc in our home town ten years ago as you were running for the Senate for your first time, I said we all need a friend in the Senate. And I'm going to interpret your visit here today as being evidence to us that you are and that we do have a friend in the Senate. And my talk is going to be a plea to a friend from a friend asking for some help, help to keep our rural hospitals alive and viable, help to keep primary care physicians in business and regaining our respect we once had from our government.

I'm a Board Certified family practice physician, in practice for seventeen years in New Albany, Mississippi. This is the county seat of Union County, a town with a population of 7,500 and a county population of slightly over 20,000. New Albany is located twenty-five miles northwest of Tupelo and about seventy miles southeast of Memphis. Our county has a 150-bed general hospital that is fully accredited and slightly over twenty years old.

Our medical staff has about twenty physicians on the active medical staff, about one half are general or family practice physicians. We have two internal medicine physicians, two general surgeons, two OB–GYN, one pediatrician, two radiologists, and a full-time pathologist. When I went there in 1972, we had five physicians, so it's obvious that a rural hospital can recruit physicians. The problem is now we've got to stay viable so we can keep them.

About 50 percent of our patients are Medicare or Medicaid with approximately two-thirds Medicaid, one-third Medicaid. Ten percent of our patients are indigent or no pay patients. We lose money on every Medicaid admission, hopefully break even on Medicare admissions, and have to make up for the indigent losses on 40 percent of our admitting population with insurance. Insurance companies know that they're being "ripped off" and are getting more and more strict about admissions and services for which they will pay.

Many rural hospitals in Mississippi and across America have had to close during the past year and many more will close in the years to come. Even more hospitals have had to sell their county owned and operated hospitals to large regional hospitals like we have seen here, or private hospital corporations to survive and keep their doors open.

This may be exactly what the "powers to be" in Washington desire to occur. Thirty years ago the federal government was encouraging the building of new rural, county-owned hospitals with Hill-Burton funds. We have now apparently gone full circle and the decision has been made at some federal level to force closure of many of these smaller rural hospitals and encourage the growth and development of large regional hospitals with some hospitals to be, at best, first aid stations. This will certainly be a hardship to the citizens of these unfortunate counties, especially the elderly.

The mid-sized county hospitals, like Union County, where I am presently chief of medical staff, must try to compete with the larger regional hospital for primary and secondary care in a very unfair competitive situation.

Union County Hospital is not a tertiary care hospital, and it never hopes to be one. We can provide primary and secondary care with general surgery and obstetrical care for our county and surrounding counties on a very adequate and cheaper basis than the nearby regional hospitals. We feel there is a strong need for this type hospital and service and we know the citizens prefer this to going farther from home to city hospitals when the service is available closer to home.

Unfortunately, our competition is paid on the urban basis, and we're paid on the rural basis, with about a 15 percent difference in the federal reimbursement for the same DRG payments on Medicare patients. This certainly gives them a competitive advantage in recruiting physicians, hiring nurses and medical personnel, and in working out attractive PPO offers to local area industries. This has been done in our county by the North Mississippi Medical Center recently, excluding our hospital from PPO arrangements with the second largest industry in our own county.

I feel there has been a conspiracy at all levels of government to discredit physicians for several years now. You cannot pick up a newspaper or hear a news program without some governmental agency accusing physicians of over-charging patients, committing malpractice, or showing no concern for the poor and the elderly in our society. HCFA operates on the general premise that all physicians are crooks and need careful watching by their peers and bureaucratic watchdogs. We have to sign our names to charts stating that the contents are the truth under punishment of the law, which I think is ridiculous. We have to sign our names to numerous documents necessary to care for our patients that we don't even have time to complete, much less read.

We're responsible for nursing care under home health on our elderly patients with many forms and documents to sign with absolutely no reimbursement. In fact, home health care will pay nurses more to make house calls than Medicare will pay doctors for doing the same thing. And I'm not being critical about home health. We need it. It's a wonderful service. We just need a little respect, too. And, yes, I do still make house calls. Most of the time I don't even turn in my fee because Medicare doesn't pay me enough to make it worthwhile.

Medicare punishes those of us who accept Medicare and try to keep our office charges down. I read recently where the average office call for a family physician in America was thirty-five dollars and twenty-five dollars in the South. My average office call is twenty dollars, and Medicare only allows sixteen dollars and ten cents for covered services and pays 80 percent of that by allowing us to try to collect the other 20 percent from the patient.

Frequently, injections and lab tests are said to be not covered and the patient is notified that the service is not covered and is unnecessary. That leads to deterioration of the doctor-patient relationship. Other services that are covered are usually paid on much less than actual cost. For instance, one gram of Monocid, a twenty-four parenteral antibiotic, costs my clinic over twelve dollars. Medicare allows slightly over four dollars reimbursement. It is obvious that we're losing money, patients, and friends very fast.

I'm the medical director of our local 120-bed nursing home. I'm paid one hundred dollars a month for that position, and I'm on call for all their emergencies. My clinic cares for over half, which means over sixty patients in that nursing home. We receive fifteen dollars for traveling across town to see a patient on Medicare or Medicaid there. Only six of our local physicians accept patients at the nursing home, and I think you can understand why.

I have practiced medicine for over sixteen years in New Albany. My annual net income is almost equal to what it was ten or twelve years ago and going down. I had to give up my OB practice last year because of the malpractice crunch. I have to work one or two nights a week in our emergency room to make ends meet with two children in college.

My oldest son graduates in engineering this coming May and plans to enter law school this fall. He is a Carrier Scholar at Ole Miss with almost perfect ACT scores in math and science going into law. No, he never considered medicine as a career, nor would I encourage him to.

I'm 46 years old, looking for another career or early retirement. Most middle-aged physicians that I know feel the very same way. Unless things change, no one will want to enter private medical care in the future, and ultimately, the patients will suffer. I think it's obvious that our present reimbursement system for primary care physicians in rural hospitals is unfair, and I hope that something can be done to correct it in the near future.

[The prepared statement of Dr. Russell follows:]

Dr. Richard Russell

PLEA FOR FAIRNESS IN RURAL HEALTH CARE FOR THE ELDERLY

I am a Board certified family practice physician, in practice for seventeen years in New Albany, MS, the county seat of Union County, with a town population of 7,500 people and a county population of slightly over 20,000. New Albany is located twenty-five northwest of Tupelo, MS, and about seventy miles southeast of Memphis, TN. Union County has a 150 bed county owned general hospital that is slightly over twenty years old.

Our medical staff has about twenty physicians on the active medical staff, about one-half in general or family practice, two internal medicine specialists, two general surgeons, two OB-GYN specialists, a pediatrician, two radiologists, and a full-time pathologist.

Almost exactly 50% of our patients are Medicaid or Medicare with approximately two-thirds being Medicare and one-third Medicaid. Ten percent are indigent or no pay patients. We lose money on every Medicaid admission, hopefully break even on Medicare admissions, and have to make up for the indigent losses on about 40% of the admitting population with insurance. Insurance companies know they are being "ripped off" and are getting more and more strict about admissions and services for which they will pay.

Many rural hospitals in Mississippi, and across America, have had to close during the past year, and may more will close in the years to come. Even more hospitals have had to sell their county owned and operated hospitals to large regional hospitals or private hospital corporations to survive and keep their doors open.

This may be exactly what the "powers to be" in Washington desire to occur. Thirty years ago the Federal Government was encouraging the building of new rural, county owned hospitals with Hill-Burton funds. We have now apparently gone full circle and the decision has been made at some federal level to force closure of many of these smaller rural hospitals and encourage the growth and development of large regional hospitals with some hospitals to be, at best, first aid stations. This will certainly be a hardship to the citizens of these unfortunate counties, especially the elderly.

The mid-sized county hospitals, like Union County, where I am presently the Chief of the Medical Staff, must try to compete with the larger regional hospital for primary and secondary care in a very unfair competitive situation.

Union County Hospital is not a tertiary care hospital, and never hopes to be one. We can provide primary and secondary care with general surgery and obstetrical care for our county and surrounding territory on a very adequate and cheaper basis than the near-by regional hospitals. We feel there is a strong need for this type hospital and service, and we know the citizens prefer this to going farther from home to city hospitals when the service is available closer to home.

Unfortunately our competition is paid on the urban basis and we are paid on the rural basis, with about a 15% difference in the federal reimbursement for the same DRG payments on Medicare patients. This certainly gives them a competitive advantage in recruiting physicians, hiring nurses and medical personnel, and in working out attractive PPO offers to local area industries. This has been done in our own county by North MS Hospital recently, excluding our hospital from PPO arrangements with the second largest industry in our own county. We feel this is terribly unfair and also very unwise with long-term risks to North MS Hospital.

I feel there has been a conspiracy at all levels of government to discredit physicians for several years now. You cannot pick up a newspaper or hear a news program without some governmental agency accusing physicians of over-charging patients, committing malpractice, or showing no concern for the poor and the elderly in our society. HCFA operates on the general premises that all physicians are money-hungry crooks and need careful watching by their peers and bureaucratic watchdogs. We have to sign our names to charts stating the contents are the truth under punishment by law, sign our names to numerous documents necessary to care for our patients that we do not have the time to complete ourselves, much less even read. We are responsible for nursing care under home health on our elderly patients with many forms and documents to sign with no reimbursement. In fact, home health care will pay nurses more to make house calls than Medicare will approve for the physician. And, yes, I do still make house calls!

Medicare punishes those of us who accept Medicare and try to keep our office charges down. I read recently where the average office call for a family physician in America was $35.00, and $28.00 in the South. My average office call is $20.00, and Medicare only allows $16.10 for "covered services" and pays 80% of that by allowing us to try to collect the other 20% from the patient. Frequently, injections and lab tests are said to be not covered and the patient is notified that the service is not covered and is unnecessary. That leads to deterioration of the doctor-patient relationship. Other services that are covered are usually paid on much less than actual cost. For instance, one gram of Monocid, a twenty-four parenteral antibiotic, costs my clinic over $12.00. Medicare allows slightly over $4.00 reimbursement. It is obvious that we are loosing money, patients, and friends fast.

I am the Medical Director for our local 120 bed nursing home. I am paid $100.00 per month for that position, and I am on call for all their emergencies. My clinic cares for over half of the patients there. We receive $15.00 for traveling across town to see a patient on Medicare or Medicaid there. Only six of our local physicians accept patients at the nursing home, and I think you can understand why. I have practiced medicine for over sixteen years in New Albany. My annual net income is almost equal to what it was 10-12 years ago and going down. I had to give up my OB practice last year because of the malpractice crunch. I have to work one or two night per week in our own Emergency Room to make ends meet with two children presently in college. My oldest son graduates in engineering this coming May and plans to enter law school this fall. He is a Carrier Scholar at Ole Miss with almost perfect ACT scores in math and science. No, he never considered medicine as a career, nor would I have wanted him to. I am 46 years old, looking for another career or early retirement. Most middle-aged physicians that I know feel the very same way. Unless things change, no one will desire to enter private primary care medicine, and ultimately, the patients will suffer. I think it is obvious that our present reimbursement system for primary care physicians and rural hospitals is very unfair, and I hope that something can be done to correct this gross injustice in the near-future.

Respectively submitted,

Richard Russell, M.D.

DIFFERENCE IN DRG RATES

	UCGH	NMMC	DIFFERENCE	%
FY 1989	2,211.59	2,523.90	312.31	14.1
FY 1988	2,120.63	2,466.29	345.66	16.3

In 33 counties, hospitals are steadily losing money. In 10 counties cash drain has tapped out their reserves and in 7 more, they are using savings to pay for daily operations.

There is a very real possibility that 15-20 hospitals will not survive.

HOSPITAL CLOSINGS

In the year 1987, ninety-six (96) hospitals closed in the United States. Of this 96, 79 were community hospitals and 17 were non-community hospitals.

In the year 1987, four (4) hospital closed in the State of Mississippi. All were non-community hospitals.

MEDICARE/MEDICAID

At Union County General Hospital the percentage of patients covered by Medicare or Medicaid is as follows:

Medicare	38%
Medicaid	13%
	51%

Bad Debts on the above runs 10%

The hospital is only collecting 65% of Medicare charges.

Senator **Cochran**. Thank you very much, Dr. Richard Russell, for your testimony and insight that you've provided to us and to our committee on some of the practical problems that are being encountered by physicians in smaller towns in our state. I think this really helps us to understand what some of the problems really are.

Thad Bridges is here representing community health centers. He is the director of the Vicksburg-Warren Community Health Center in Vicksburg, Mississippi.

Mr. **Bridges**. Senator Cochran, it is a pleasure for me to appear before you and the U.S. Senate Subcommittee on Aging. Also, I am pleased to represent the Mississippi Primary Health Care Association as its vice-president and as executive director of the Vicksburg-Warren Community Health Center.

I accept this opportunity to share with this Committee the recommendation to provide improved access to health care for the elderly of our state. Before I state my recommendations, Senator Cochran, I would like to inform you and the Committee about community health centers.

Community health centers, which began in 1965, have developed into a national network of over six hundred primary health care centers providing services to nearly six million poor and underserved Americans in fifty states, Puerto Rico, and the District of Columbia.

In Mississippi, the need for community health centers has never been greater. The increase in the number of families living in poverty without health insurance and the number of elderly Mississippians unable to afford the high cost of medical care has made the centers even more necessary and a valuable asset to the communities they are serving. The past decade has brought much progress in the publicly supported health care system as community health centers have spread across the state. The centers are situated in both urban and rural areas with twenty-one separate organizations providing services at forty-two locations in the state.

Community health centers do not interfere with or duplicate the efforts of other private practice providers as they are located in areas where there is a shortage of personal health services.

Community health centers are staffed by primary care physicians. The centers provide comprehensive health services to infants, children, adolescents, expectant mothers, men and women, young adults, middle-aged adults and elderly citizens. Those services provided include medical, dental, radiological, pharmacy, nutrition, health education, social services and transportation.

During calendar year 1987, these centers provided services to more than 165,000 Mississippi citizens and recorded an excess of 575,000 patient visits. Of these figures, 29 percent of services were provided to the elderly. For the first six months of 1988, the state's community health centers delivered 12.5 million dollars in needed health care services to 101,032 users, of which 11.5 percent were 65 years old and older.

As of October the 1st, 1988, community health centers in Mississippi have a total of eighty-four physicians. Twenty-nine physicians are grant hire and fifty-five are federally hired. By the end of July 1989, there will be thirty-nine federally hired physicians. By the end of July 1990, there will be only twenty federally hired physicians. By the end of 1991, there will be four federally hired physicians, and by August 1992, all federally hired physicians will be exhausted. The problem is now compounded due to the fact that there are no physicians in the "pipeline."

Senator, in order to provide the needed health care in the state for fiscal year 1988-1989, we will need to replace the sixteen physicians who are leaving and recruit and retain forty-two additional physicians. In fiscal year 1989-1990, we will need to replace nineteen physicians that will be leaving the state.

Despite their record of achievement, health centers still reach less than one-fourth of America's 25 million medically underserved residents. The need to strengthen the capacity of health centers has grown more urgent in recent years, as the number of families living poverty and without health insurance has grown and the number of elderly Americans unable to afford the high cost of medical care has increased.

Patient issues includes both availability and affordability of care. If no care is available or if continuity of care is interrupted or poorly coordinated, all potential patients suffer. Interruptions in availability of care and current lack of services are serious problems facing all rural residents, and reasons for availability problems are increasingly economic in nature. Regardless of improvements which might be made in availability of care, affordability will remain a separate but related issue. In small communities or sparsely-populated areas, the people may be forced to do without health services all together.

We recommend, Senator, that community and migrant health centers receive an increase in funding levels in order to recruit and retain needed physicians in rural areas, keeping in mind that rural areas have special needs. And let me emphasize that again, Senator. They do have special needs.

Our other recommendation, as many have stated before me, will be for equal reimbursable Medicare and Medicaid rates that would parallel rural and urban areas in the delivery of health care services. I further would like to submit to the Committee documents for your review, and those documents include: (1) NHSC Physicians By the End of Tour Date, fiscal year 1992; (2) Community Health Centers in Mississippi; (3) Community and Migrant Health Centers: Two Decades of Achievement; (4) National Groups Call for Reform and Rural Health Care Delivery; and (5) Health Care in Rural America: Crisis Unfolds.

Thank you for inviting us, Senator.

[Information submitted by Mr. Bridges follows:]

NHSC PHYSICIANS BY END OF TOUR DATE

SUMMARY

PERIOD OF 10/88--7/89:	16
PERIOD OF 8/89--7/90:	19
PERIOD OF 8/90--7/91:	16
PERIOD OF 8/91--7/92:	4

NAME	SPECIALITY	TYPE OF ASSIGNMENT	COUNTY	EOD	EOT	CHC
Jones, Robin	MD-INT	NHSC-CS	Bolivar	14-Sep-86	13-Nov-88	Delta Health Center
Ward-Washington, Cherese	MD-INT	NHSC-PPA	Bolivar	22-Oct-84	21-Oct-88	Delta Health Center
Gaskin, Charles	MD-OBG	NHSC-CS	Jones	30-Oct-85	29-Oct-88	South MS CHC
Rose, Julian	MD-INT	NHSC-CS	Lauderdale	10-Sep-85	09-Dec-88	Greater Meridian
Walker-Eaddy, Maria	MD-GP	NHSC-PPA	Humphreys	28-Sep-87	31-Dec-88	Madison-Yazoo-Leake FHC
Murphree, Duaine	MD-FP	NHSC-CS	Lauderdale	01-Mar-87	28-Feb-89	Greater Meridian HC
Harrell, Bernard	DO-GP	NHSC-PPA	Scott	08-Jul-85	07-Jul-89	East Central MS Health
Butler, Gloria	MD-FP	NHSC-PPA	Claiborne	15-Jul-85	14-Jul-89	Claiborne County CHC
Patterson, Ruth	MD-PED	NHSC-PPA	Hinds	15-Jul-85	14-Jul-89	Jackson-Hinds CHC
Reed Alphonse	MD-INT	NHSC-PPA	Jefferson	15-Jul-85	14-Jul-89	Jefferson CHC
Patterson, Michael	MD-FP	NHSC-PPA	Marshall	15-Jul-86	14-Jul-89	Northeast MS Health Care
Smith, Diana	MD-INT	NHSC-PPA	Harrison	21-Jul-86	20-Jul-89	Coastal Family Health
Miller, Rosemary	MD-FP	NHSC-PPA	Tunica	20-Jul-86	29-Jul-89	Aaron E. Henry CHC
Gibney, Michael	MD-OBG	NHSC-PPA	Harrison	01-Aug-87	31-Jul-89	Coastal Family Health
Bacon, Janice	MD-PED	NHSC-PPA	Madison	01-Aug-86	31-Jul-89	Madison-Yazoo-Leake FHC
Brundage, Stephanie	MD-FP	NHSC-PPA	Perry	01-Aug-85	31-Jul-89	Southeast MS Rural Health

TOTAL PHYSICIANS WITH OBLIGATIONS ENDING PERIOD OF 10/88--7/89: 16

This is 29% of NHSC physicians at CHCs and 20% of total physicians at CHCS.

NAME	SPECIALITY	TYPE OF ASSIGNMENT	COUNTY	EOD	EOT	CHC
Mitchell, Mark	MD-OBG	NHSC-PPA	Harrison	12-Aug-85	11-Aug-89	Coastal Family Health
Marshall, Demetri	MD-FP	NHSC-PPA	Claiborne	01-Jul-87	30-Aug-89	Claiborne County CHC
Carlson, Judy	MD-PED	NHSC-CS	Jones	03-Sep-86	02-Sep-89	South MS CHC
Worrell, Kevin	MD-PED	NHSC-PPA	Hinds	09-Sep-85	08-Sep-89	Jackson-Hinds CHC
Evans, Thomas	MD-FP	NHSC-PPA	Marshall	19-Sep-85	18-Sep-89	Northeast MS Health Care
Spence, Paula	MD-INT	NHSC-PPA	Hinds	25-Sep-85	24-Sep-89	Jackson-Hinds CHC
LeNoir, Daniel	MD-FP	NHSC-PPA	Harrison	11-Jul-87	30-Jun-90	Coastal Family Health
Gordon, Raymond	MD-PATH	NHSC-PPA	Hinds	01-Jul-87	30-Jun-90	Jackson-Hinds CHC
Bartley-Rice, Debra	MD-INT	NHSC-PPA	Hinds	01-Jul-86	30-Jun-90	Jackson-Hinds CHC
Perkins, Issac	MD-INT	NHSC-CS	Jones	01-Jul-87	30-Jun-90	South MS CHC
Shaw, Frederick	MD-PED	NHSC-CS	Warren	07-Jul-86	06-Jul-90	Vicksburg-Warren CHC
Savare-Jones, Arlillian	MD-FP	NHSC-PPA	Tunica	14-Jul-86	13-Jul-90	Aaron E. Henry CHC
Horner, Philip S.	MD-FP	NHSC-PPA	Lawrence	14-Jul-86	13-Jul-90	South Central MS RH
Handshoe, David	MD-INT	NHSC-PPA	Harrison	15-Jul-87	14-Jul-90	Coastal Family Health
Binion, Louis B.	MD-INT	NHSC-CS	Lauderdale	15-Jul-86	14-Jul-90	Greater Meridian HC
Castilla, Magolia	MD-PED	NHSC-PPA	Yazoo	16-Jul-86	14-Jul-90	Madison-Yazoo-Leake FHC
Williams, Ada	MD-PED	NHSC-CS	Jones	20-Jul-86	19-Jul-90	South MS CHC
Townsend, Horrell	MD-OBG	NHSC-PPA	Harrison	01-Aug-86	31-Jul-90	Coastal Family Health
Anderson, Donna	MD-OBG	NHSC-PPA	Hinds	01-Aug-86	31-Jul-90	Jackson-Hinds CHC

TOTAL PHYSICIANS WITH OBLIGATIONS ENDING PERIOD OF 8/89--7/90: 19

This is 35% of NHSC physicians at CHCs and 23% of total physicians at CHCS.

NAME	SPECIALITY	TYPE OF ASSIGNMENT	COUNTY	EOD	EOT	CHC
Overstreet, Alphonzo	MD-OBG	NHSC-PPA	Hinds	15-Aug-88	14-Aug-90	Jackson-Hinds CHC
Burney, Dawn	MD-GP	NHSC-PPA	Bolivar	15-Sep-86	14-Sep-90	Delta Health Center
Morgan, Joneice T.	MD-INT	NHSC-CS	Lauderdale	11-Oct-88	10-Oct-90	Greater Meridian
Rigsby, Reginald	MD-FP	NHSC-CS	Warren	20-Jul-87	19-Jan-91	Vicksburg-Warren CHC
Howell, Michael	DO-GP	NHSC-PPA	Benton	15-Jun-87	14-Jun-91	North Benton CHC
Salazar-Tier, Mary	MD-FP	NHSC-PPA	Jackson	01-Jul-87	30-Jun-91	Coastal Family Health
Siegel, Robert	MD-PED	NHSC-PPA	Harrison	01-Jul-87	30-Jun-91	Coastal Family Health
Bush, Freda	MD-OBG	NHSC-PPA	Hinds	01-Jul-87	30-Jun-91	Jackson-Hinds CHC
Ballard-Thompson, Catherine	MD-FP	NHSC-PPA	Hinds	01-Jul-87	30-Jun-91	Jackson-Hinds CHC
Main, Roy	MD-INT	NHSC-PPA	Hinds	01-Jul-87	30-Jun-91	Jackson-Hinds CHC
Myers, Ronald	MD-FP	NHSC-PPA	Humphreys	01-Jul-88	30-Jun-91	Madison-Yazoo-Leake FHC
Carr, Gary	MD-FP	NHSC-PPA	Covington	01-Jul-87	30-Jun-91	Southeast MS Rural Health
Simpson, Helen	MD-FP	NHSC-PPA	Leake	15-Jul-87	14-Jul-91	Madison-Yazoo-Leake FHC
Droffner, Mark C.	DO-FP	NHSC-PPA	Amite	20-Jul-87	19-Jul-91	Amite County Medical
Harris, Dona	MD-FP	NHSC-PPA	Lawrence	29-Jul-87	28-Jul-91	South Central MS RH
Gaines, Sharon	MD-PED	NHSC-PPA	Bolivar	01-Aug-88	31-Jul-91	Delta Health Center

TOTAL PHYSICIANS WITH OBLIGATIONS ENDING PERIOD OF 8/90--7/91: 16

This is 29% of NHSC physicians at CHCs and 20% of total physicians at CHCS.

Phillips, Andrea	MD-FP	NHSC-PPA	Hinds	01-Sep-87	31-Aug-91	Jackson-Hinds CHC
Beaver, Lenworth	MD-OBG	NHSC-CS	Jones	29-Sep-87	28-Sep-91	South MS CHC
Johnson, Veda	MD-PED	NHSC-CS	Lauderdale	18-Jul-88	17-Jul-92	Greater Meridian HC
Sessions, Fadrienne H.	MD-PED	NHSC-PPA	Hinds	01-Aug-88	31-Jul-92	Jackson-Hinds CHC

TOTAL PHYSICIANS WITH OBLIGATIONS ENDING PERIOD OF 8/91—7/92: 4

TOTAL NHSC PHYSICIANS AS OF 10/1/88	55
TOTAL NON-NHSC PHYSICIANS AS OF 10/1/88	29
TOTAL PHYSICIANS AT CHCS	84

COMMUNITY HEALTH CENTERS

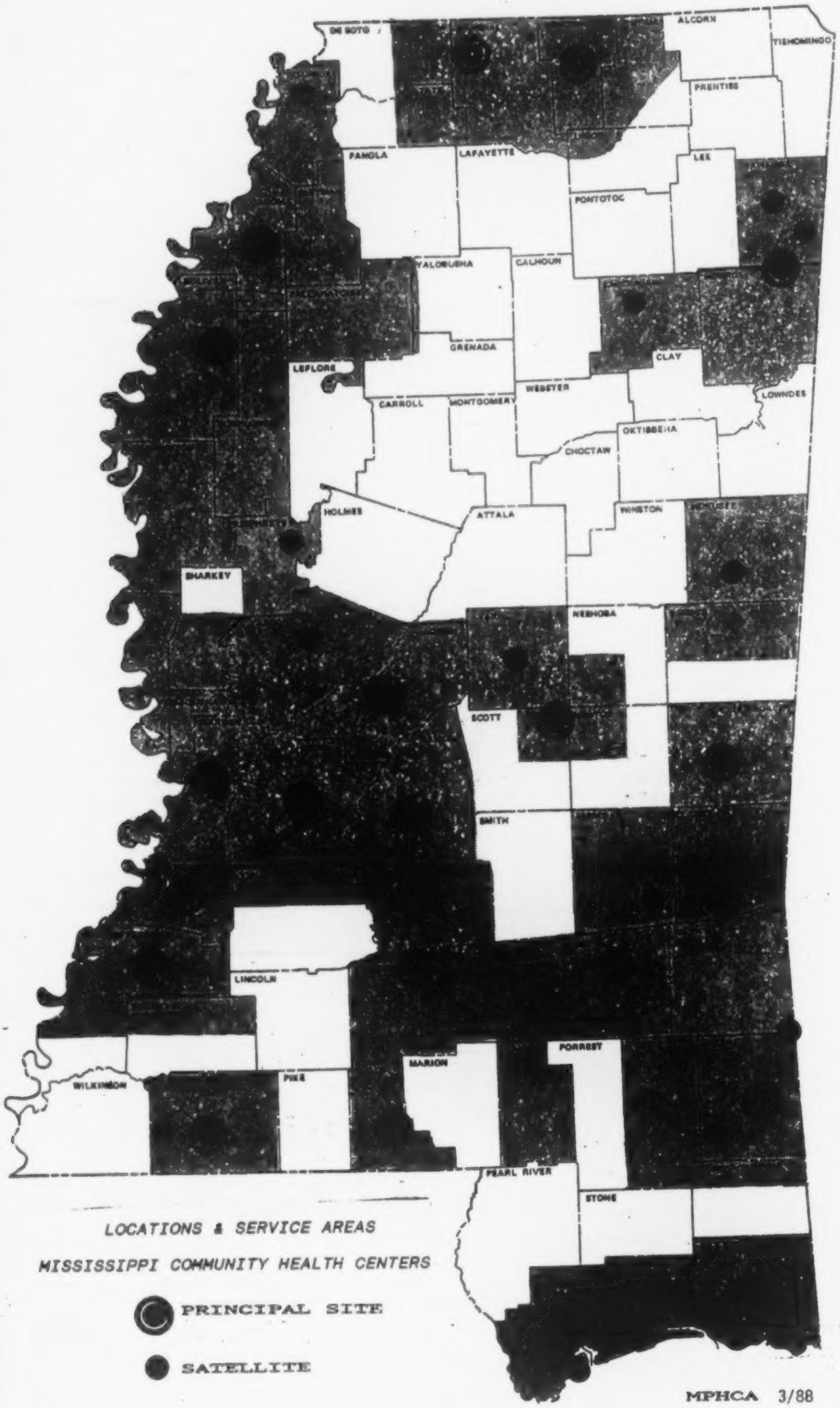
Community Health Centers are private, non-profit corporations with community-based governance and are eligible to receive federal grants from the Department of Health & Human Services under Section 330 of the Public Health Service Act. These funds, together with fees collected at the centers, are used to provide comprehensive health services to residents of urban and rural areas where there are shortages of medical personnel and services or where access to health care is limited due to financial barriers and other economic conditions. The health status and special health needs of the community are also factors in awarding funds for these centers. Community Health Centers attempt to coordinate federal, state and local resources in a single organization capable of delivering both health care and related social services to a defined population. The mission of the Community Health Center is to provide primary care services in an atmosphere of dignity and concern to populations which face significant access barriers to the health care system.

Community Health Centers have been cited as the most effective and efficient systems yet developed to provide a true health care "safety net" for the medically disadvantaged. This program, which began in 1965, has developed into a national network of over 600 primary health care centers providing services to nearly six million poor and underserved Americans in 50 states, Puerto Rico, and the District of Columbia. For millions of our country's most vulnerable citizens, health centers are increasingly becoming their only potential source of affordable care.

In Mississippi, the need for Community Health Centers has never been greater. The increase in the number of families living in poverty, without health insurance, and the number of elderly Mississippians unable to afford the high cost of medical care has made the centers even more necessary and a valuable asset to the communities they are serving. The past decade has brought much progress in the publicly supported health care system as Community Health Centers have spread across the state. The centers are situated in both urban and rural areas with 21 separate organizations providing services at 42 locations in the state, staffed by over 130 health care providers, as reflected on the attached list and the accompanying map.

Community Health Centers do not interfere with or duplicate the efforts of other private practice providers as they are located in areas where there is a shortage of personal health services. Thus, their role is both appropriate and vitally necessary. The federal support received by the centers is used to subsidize the cost of care for indigent, uninsured persons, to cover the cost of non-reimbursable services such as preventive care and health education, and to establish the capacity for the delivery of health service in such areas. In effect, the health centers serve to insure their local communities against the cost of care for the uninsured; even if other providers were available to serve these persons, the cost of their care would have to be met through increased state or local taxes.

Community Health Centers are staffed by primary care physicians, the majority of whom have completed residency programs in their specialty; dentists; and other auxiliary providers. The centers provide comprehensive health services, including medical, dental, radiology, pharmacy, nutrition, health education, social services and transportation. During calendar year 1987, these centers provided services to more than 165,000 Mississipi citizens and recorded in excess of 575,000 patient visits.



LOCATIONS & SERVICE AREAS
MISSISSIPPI COMMUNITY HEALTH CENTERS

MPHCA 3/88

MISSISSIPPI COMMUNITY HEALTH CENTERS
Selected Data, 1988

Center Name & Clinic Sites	Counties Served	Providers
Aaron E. Henry Community Health Center Clarksdale Tunica	Coahoma, Tallahatchie, Quitman & Tunica	3 Physicians 1 INT, 2 FP
Amite County Medical Services, Inc. Liberty (Medical) Gloster (Dental)	Amite	1 Physician DO/FP 1 Dentist
Claiborne County Community Health Center Port Gibson	Claiborne	2 Physicians 2 FP
Coastal Family Health Center Biloxi Gulfport Saucier Bay St. Louis Delisle Vancleve	Jackson, Hancock, Harrison, Stone Pearl River	10 Physicians 2 INT 3 OBG 2 FP 1 GP 2 PED 2 Dentists 2 FNP 1 NM 1 Pharmacist
Delta Health Center Mound Bayou	Bolivar & Sunflower	6 Physicians 2 GP 1 FP 2 INT 1 PED 3 Dentists 1 Pharmacist 1 NP 1 NM
East Central MS Health Care, Inc. Sebastopol	Scott, Neshoba, Leake & Newton	1 Physician DO-GP 1.5 Dentists 1 NP
Greater Meridian Health Clinic Meridian Shuqualak	Lauderdale, Noxubee & Kemper	4 Physicians 2 INT 1 FP 1 PED 3 Dentists 1 Pharmacist
Greene Area Medical Extenders Leakesville McClain State Line	Greene & Wayne	3 Physicians 3 GP 1 Dentist
Jackson-Hinds Comprehensive Health Center Jackson Utica	Hinds & Copiah	17 Physicians 4 INT 6 PED 3 FP 3 OB/GYN 1 PATH 3 Dentists 1 Pharmacist 3 NP

MISSISSIPPI COMMUNITY HEALTH CENTERS
Selected Data, 1988

Center Name & Clinic Sites	Counties Served	Providers
Jefferson Comprehensive Health Center Fayette	Jefferson, Adams & Franklin	3 Physicians 1 FP, 1 INT 1 OB/GYN 1 Dentist 1 Pharmacist
Madison-Yazoo-Leake Family Health Center Canton Yazoo City Carthage Belzoni	Madison, Yazoo Leake & Humphreys	7 Physicians 4 FP, 2 PED 1 PATH 2 Dentist 1 NM
North Benton County Health Care Ashland	Benton, Marshall, Tippah, Union & Tennessee	1 Physician FP 1.5 Dentists
Northeast MS Health Care Byhalia	Marshall, DeSoto, & Tate	3 Physicians 2 FP 1 GP 1 Dentist
Outreach Health Services Shubuta Heidelberg	Clarke, Wayne & Jasper	2 Physicians 2 FP 1 Dentist
Rankin County Health Care Center Rankin	Rankin	3 Physicians 1 FP, 1 PED, 1 INT 1 Dentist 1 NP
South Central Ms Rural Health New Hebron Mendenhall	Simpson, Lawrence, & Jeff Davis	3.5 Physicians 2 FP, 1 GP .5 INT 1 Dentist
South MS Community Health Center Laurel	Jones	5 Physicians 2 PED, 1 INT 2 OB/GYN 1 Pharmacist
Southeast MS Rural Health Initiative Seminary Sumrall New Augusta	Covington, Lamar, & Perry	3 Physicians 3 FP
SW Health Agency for Rural People Tylertown	Walthall	1 Physician -GP 1 Dentist
Three Rivers Area Health Services Smithville Tremont Houlka Mantachie	Itawamba, Monroe, & Chickasaw	3 Physicians 3 FP
Vicksburg-Warren CHC Vicksburg	Warren, Issaquena & Sharkey	3 Physicians 1 FP, 1 PED 1 INT 1 NP 1 Pharmacist

MISSISSIPPI COMMUNITY HEALTH CENTER STATISTICS
JAN--JUNE 1988 BCRRs
SIX-MONTH DATA

21 Organizations with 42 Delivery Sites

Total No. of Medical Users:		85,276	
Age 65 and Over	9,819 (11.5%)		
Total No. of Dental Users:		15,756	
Total Medical and Dental Users:			101,032
Total Encounters (Medical, Dental, Other Health)			308,962
Total Physicians:		82	
Total Dentists:		21	
Total Midlevels		12	
Total Providers:			115
Total Employees:			650
Total Operating Cost:		$12,452,611	
Total 330 Grant Funds Received:		7,594,880	
Percent of Operating Cost:			61%
Total Medicare Collections:		1,001,520	
Percent of Operating Cost:			8%
Total Medicaid Collections:		1,304,468	
Percent of Operating Cost:			10%
Total Other Third Party Collections:		256,469	
Percent of Operating Cost:			2%
Total Patient Collections:		1,733,920	
Percent of Operating Cost:			14%

The Health Center Context

The mid-1960s witnessed the initiation of a wave of voluntary physician efforts to render basic health services to the poor, and "store-front" clinics proliferated across the country. In 1966, as part of the national administration's "War on Poverty," health centers were established in rural Mound Bayou, Mississippi and Boston's Columbia Point—two communities especially characterized by severe economic distress and poor health status. The federal Office of Economic Opportunity (OEO) then began granting funds to a number of newly-formed Neighborhood Health Centers (the forerunners of Community Health Centers), which developed a spectrum of health and social services for the economically disadvantaged.

In 1973, federal responsibility for supporting these programs passed to the Department of Health, Education and Welfare (now Health and Human Services, or DHHS); and Community Health Centers—together with Migrant Health Centers geared to serve migrant farmworkers and their families—became more directly oriented toward the provision of medical care. During the ensuing decade, clinical services expanded, and the effectiveness and efficiency of health center methods of care delivery steadily increased.

Twenty years after their initiation, federally-funded Community and Migrant Health Centers had by 1986 increased in number to 560, with approximately 1500 clinic sites serving almost six million people—thus comprising a significant component of America's health care resources. During this period of progress, the National Association of Community Health Centers (NACHC) has aided its health center constituency by providing government policy analysis information, health education services, and operational technical assistance. Further, NACHC has established effective national-level clinical and quality assurance task forces, and it has fostered the formation of a network of viable state-level primary care associations comprising health center administrators and clinicians.

All health centers that receive federal support have certain elements in common:

- Governance by a community-based Board of Directors, the majority of whom are users of health center services;
- Administration by an Executive Director who is responsible to the Board of Directors;
- Staffing by a Medical Director and other clinical personnel;
- Rendering health care to populations and areas that have been federally designated as medically underserved;
- Providing basic primary health care plus support and facilitation of other ancillary services; and
- Adjusting the cost of services to the patient's and family's ability to pay.

The great majority of the nation's health centers are organized as private "non-profit" corporations. In the main, health centers receive about one-half their operating support from direct federal grants administered by the Bureau of Health Care Delivery and Assistance (BHCDA) within DHHS. This income helps to cover start-up costs and to defray the expense of providing care to the medically uninsured. The balance of operating support is produced from patient fees, public and private insurance programs, and state, local or other contributions.

The population of almost six million persons served by health centers has the following overall characteristics: 64 percent represent minorities (Black: 31%; Hispanic: 28%; and other: 5%). Forty-five percent are children under 20 years of age, 43 percent are in the 20-64 age range, and 12 percent are 65 or over. Almost two-thirds of the users of services live below the poverty level, while another 25 percent have incomes between 100 and 200 percent of poverty. Yet these aggregate figures only hint at the uniqueness or diversity of specific patient populations that utilize the services of individual health centers.

In terms of locale, health centers may be found in every state and territory, in areas rural and urban, and in a wide variety of ecological settings. Depending on their locations and the size and needs of the communities in which they are found, health centers range from rural clinic sites with a small core of physicians and auxiliary providers, to large urban clinical networks with a full range of medical, dental, nursing, and social service health care delivery and training programs. Moreover, each center has its own special history and experience-based approach for adapting its staffing patterns and services to meet the particular sociocultural and epidemiological requirements of the community it serves. In so doing, a health center may utilize a variety of approaches, such as perinatal initiatives; maternal and child health programs; nutrition services; school-based health promotion projects; translation, transportation, and inter-agency service coordination; mental health services; and home health care for the elderly.

Central to the effective clinical functioning of every health center is an appropriate combination of dedicated physicians who are board certified or board eligible in one of the four recognized primary care medical disciplines: family practice, internal medicine, obstetrics-gynecology, and pediatrics. In addition to medical practice, these physicians usually engage in a variety of health center programmatic functions and community health activities. Moreover, many health centers have established training components formed in conjunction with primary care residency training programs and medical school departments. Those endeavors are directed by health center physicians with faculty appointments who supervise preceptorships, including ambulatory care clinical rotations for primary care medical residents and community medicine/preventive medicine clerkships for medical students.

* * *

National Association of
Community Health Centers, Inc.

MPHCA
MAY 16 88
RECEIVED

May 13, 1988

Mr. Ron Crawford
Executive Director
Mississippi Primary Health
Care Association
P.O. Box 89
Newton, MS, 39345

Dear Mr. ~~Crawford~~: Ron

We are writing to alert you about the attached report and news release which will be released to the press on Thursday, May 19. The report, entitled "Health Care in Rural America: The Crisis Unfolds," is the product of a collaborative effort between the National Association of Community Health Centers and the National Rural Health Association.

The report will be released out of Washington and will be mailed to news media all over the country. You have been listed as the contact person in case the media in your state want a comment from you about the report and/or want to know how the problems outlined in the report apply to your state.

We request that you do not speak for attribution about this report before Wednesday, May 18, so that we can have a single national announcement. If you have any questions, please feel free to call either one of us (Kathy Kiedrowski at 202-659-8008 or Bob Van Hook at 816-756-3140), or Andy Burness, our media consultant for this project, at (301) 652-1558.

Thanks in advance for your cooperation.

Sincerely,

Kathy Kiedrowski

Kathy Kiedrowski
Health Services Specialist

Enclosure(s)

1330 New Hampshire Avenue, N.W. Washington, D.C. 20036 (202) 659-8008

FOR FURTHER INFORMATION, CONTACT
Robert Van Hook
National Rural Health Association
301 E. Armour Blvd., Kansas City, MO 64111
816-756-3140 or
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National Association of
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Washington, D.C. 20036
202-659-8008

FOR RELEASE WITH
A.M. PAPERS
Thurs. May 19, 1988

NATIONAL GROUPS CALL FOR REFORM IN RURAL HEALTH CARE DELIVERY

WASHINGTON, D.C. -- Two of the nation's leading groups concerned with health in rural America today decried the state of rural health care and called for a series of specific solutions for improving the situation.

A deteriorating health care system, worsened by a failing rural economy, was described in a report entitled "Health Care in Rural America: The Crisis Unfolds." The report, commissioned by the National Rural Health Association and the National Association of Community Health Centers, highlights the critical need for health services, hospitals, physicians, and nurses, problems which have been exacerbated by the steady decrease in their availability. Its findings are also endorsed by a number of other national organizations which are concerned with health issues.*

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* See attached list of supporting organizations and contact persons

"This country is not serving the health needs of its rural citizens," stated Dr. Alan Strange, Chair of the Rural Task Force of the National Association of Community Health Centers. "The result of unsatisfactory care is a rural population that needlessly suffers from chronic disease and conditions which could often have been prevented with improved access and intervention."

The crisis in health care is particularly serious for those with more than the most basic health problems. "You better think twice about living in a rural area if you are a high-risk mother, a high-risk infant, an AIDS patient, an elderly person with chronic health problems, or the victim of an accident," said Dr. Strange. "Rural areas are sorely lacking in comprehensive health care," he stated, "ranging from limited emergency care to few opportunities for long-term coordinated treatment."

The report looks at the high rate of infant mortality as one example of the poor state of health care in rural America. The United States as a nation has declined from 6th to a tie for last place among 20 industrialized nations in combating infant mortality, and within this country, rural Americans have rates higher than their white and minority counterparts in urban areas. The problem is exacerbated by the malpractice insurance crisis that is forcing family practice physicians out of obstetrical services.

The health plight of migrant workers is also discussed in the report. It describes them as an "outsider" group moving from community to community, always far from family and social support groups. "Their outsider status places them at the bottom of the priority pyramid when services are available, and keeps them from finding system access points which are often not well understood even by long-term residents," the report says.

The report concludes that the health care systems of rural America are inadequate to serve the needs of those who depend on them, citing problems such as:

-Three-quarters of the rural poor do not qualify for public assistance.

-The lack of comprehensive prenatal care combined with the problems of poverty in rural areas has led to high rates of infant mortality, particularly for Blacks who face a 25% increase over their counterparts in urban areas.

-Rural residents have a 15% higher rate of uninsuredness than the U.S. average, and a 24% higher rate than their metropolitan counterparts. This leads to a cash drain on the rural family: rural residents pay, on average, 10% more of their income out-of-pocket for health care than their urban counterparts.

-At a time when rural needs for physicians are high, the National Health Service Corps, an important source of physicians for rural areas, is being dismantled.

-Rural hospitals are closing at a record-setting pace.

-Systems of reimbursement and insurance are geared to high-volume areas, often making the cost of providing services to rural areas too burdensome for physicians and hospitals.

- The nationwide nursing crisis and malpractice insurance crisis are hitting rural areas particularly hard, often leading to the inability to access entry level care.

"We felt it was important to join together in an effort to raise public concern about these problems," stated Kevin Fickenscher, M.D., Past President of the National Rural Health Association. "Our goal is to increase public debate on the problems and focus attention on these proposed solutions," Dr. Fickenscher added.

Among the specific recommendations for federal and state policy makers in the report are the following:

-Reform of health manpower programs and state statutes to more effectively recruit, retain and utilize health care professionals in rural areas.

-Full funding of the Community/Migrant Health Center and National Health Service Corps programs to assure the availability of care and providers in rural areas.

-Revision and full implementation of government reimbursement policies to provide equity to rural hospitals, to increase participation in the Rural Health Clinic Act, to foster incentives to attract health care providers to rural areas.

-Pursuit of public/private initiatives designed to enhance health insurance coverage for the growing number of Americans without health coverage.

-Development of model legislation and strategies to encourage states to address the malpractice insurance crisis and its negative impact on access to obstetrical services and infant mortality.

-Development of programs for rural areas to address public health problems such as AIDS, infant mortality and homelessness.

The National Rural Health Association is a national membership organization of individuals and organizations with an interest in rural health. Its members include administrators, researchers, doctors, nurses, and other health professionals from hospitals, community and migrant health centers, private practices, universities, and units of government.

The National Association of Community Health Centers is a national membership organization of over 600 Community and Migrant Health Centers, most of which provide health services to America's rural residents.

# # #

PRIMARY CARE
[illegible]

National Association of Community Health Centers, Inc. Summer/Fall 1988

Medicaid And The Rural Poor: Problems And Recommended Actions

As providers of care to the poor and near poor, Community and Migrant Health Center personnel should applaud the recent changes in Medicaid effected through congressional Medicare Catastropic Care legislation and other avenues. But we should not forget that one must achieve eligibility to obtain services and that there are many eligibility regulation packages as there are states. Rural areas are at a disadvantage in comparative Medicaid coverage. Taken as a whole, 75 percent of those rural residents who fall below the federal poverty level are found to be ineligible for financial assistance. For the one in four applicants who becomes designated as eligible, the coverage is often inadequate. At present, 70 percent of the nation's rural poor live in states where the maximum AFDC benefits are below the national median. Poor rural residents are 44 percent more likely to have no health insurance, including Medicaid, than are their metropolitan counterparts.

Community and Migrant Health Centers are a crucial part of what has become known as the "safety net." There are, in many states, wide gaps between the federal poverty level and the level of income which triggers eligibility for public assistance. The grant dollars which health centers receive are legitimately used to bridge those gaps, and to assure access to care where Medicaid levels are considered to be inadequate, particularly in the South. Current rural economic trends, however, place increasing pressure on those funds from the upper end of the sliding fee scale. Recent research shows that rural health centers are experiencing more applications to move from full pay to sliding fee status, more money tied up in accounts receivable, and more extensive write-offs of bad debt. Such increasing pressure without equivalent increases in funds available for care of the new poor and near poor will lead inexorably to prioritization and loss of necessary basic services as centers attempt to meet greater need with fewer resources. Yet opportunities do exist at the local, state and national levels to work toward equitable distribution of existing funds, as well as potential expansion of eligibility.

The Local Level

We are often told that rural people are too proud to apply for Medicaid. There is a stigma attached to public assistance, and smaller percentages of rural patients have such coverage, but lack of coverage does not assume failure to pay for services. That assumption carries with it the feeling that rural centers currently subsidize care for which Medicaid should be paying, and is part of the general myth which leads to the rationale that health centers can be expected to cut five or ten percent of "fat" each year. There is no data which demonstrate that centers are using grant funds to subsidize care of those eligible patients who are too proud to apply for Medicaid. There is every indication, however, that Medicaid eligibility regulations tend to discriminate against the rural poor, perhaps because of property definitions, intactness of families, or other variables. Centers should, and do, review user financial status at regular intervals to assure maximum allowable collection from third party payors, both public and private. The decision to seek public assistance or sliding fee discounts for needed care is up to the patient. If that patient wishes to remain on full fee status and request a time payment schedule, it is consistent with our expressed values of human dignity and personal improvement for the health center to consider such an arrangement, consistent with adequate review of cash flow needs and collection histories to assure non-interruption of care to other patients because of non-collection under such time payment schedules.

Under present economic conditions, however, more rural patients and families will be applying for financial assistance, including Medicaid. At the local level, rural Community and Migrant Health Centers can take some actions now to help meet the growing need for financial assistance, including:

- Review and revise, as necessary, policies designed to protect the dignity of patients applying for assistance, or receiving care at discount rates. Over time health center personnel leave and are replaced, and therefore we cannot assume that such policies will be executed without *ongoing staff training*. No one likes to admit the inability to pay for care, much less to ask for charity. This problem is especially critical in enclosed communities where everyone knows everyone else, a situation common to both small rural communities and deep poverty urban enclaves. Successful outreach in such areas depends on word of mouth, and a few unsatisfactory patient experiences can provide a serious barrier to community relations.
- Provide appropriate training for key staff on current Medicaid eligibility and regulations. States vary on both counts, and eligibility regulations often represent a morass which a state government itself may find difficult to understand. There is very little change that health center staff members can become acknowledged experts in eligibility. A closer working relationship with the local government technicians, however, can develop understanding of the rough working guidelines needed to facilitate the eligibility process. It is necessary to find out if a state government has incorporated the provisions of OBRA (Omnibus Reconciliation Act of 1987)

which would permit center staff to assume or determine eligibility under certain conditions. In either case, center staff should know enough about the state operation, and key local people, to assist patients who apply through this often difficult process. Reimbursement also varies by state, but regardless of state-to-state differences, the fact that remains that Medicaid should pay for Medicaid services. Especially if Medicaid has not been a substantial part of center revenue, staff may need training to maximize reimbursement as a means of recovering the true cost of service provision.

- Collect patient population economic data to ensure an ongoing assessment and planning capability. Changes in fee-for-service status, Medicaid eligibility, and third party reimbursement will be increasingly important as costs continue to rise. Good data at the individual center level is necessary to determine *who* is paying for patient care and to assure that the payor is, to the maximum extent possible, reimbursing the true cost of that care. Grant funds provided for uncompensated care should not have to subsidize the patient care for which other payors are responsible.
- Work with other centers in their respective states to assess the need for change in state Medicaid eligibility and reimbursement policies, including measures designed to increase or facilitate eligibility, such as the OBRA provisions, as well as measures which may assist centers in collecting the true cost of care, such as cost-based reimbursement options (e.g., PL95-210, The Rural Health Clinics Act).

The State Level

Rural Community and Migrant Health Centers may be effective change agents at the state level, especially by working together through State Primary Care Associations (SPCAs). Using collective data based on individual center experiences, such groups should encourage state Medicaid agencies to review and revise policies as necessary to obtain outcomes, including:

- Assurance that eligibility criteria do not capriciously discriminate against some groups. Some definitions of assets or income may immediately exclude farm families and should receive a close review. The SPCA may request a working committee - including state Social and Rehabilitative Services staff, association members, and consumers -to be established to review such policies and provide recommendations.
- Assurance that eligible families and individuals are not denied care because of process complication or difficulty. In some cases, OBRA provisions have been designed to facilitate the cumbersome eligibility determination process, and their adoption should be encouraged.
- Assurance that Medicaid reimbursement covers the true cost of providing care for Medicaid patients. Centers should emphasize the proven cost efficiency of their operational design. In fee-for-service reimbursement systems, this may mean negotiation of a separate provider category. In some cases, it may mean encouragement of acceptance of cost-based inclusive reimbursement rates. In all cases, locally developed data will be important as it shows both true costs of care and cost-effective operations.

State governments have come under heavy pressure during the past several years. They have been asked to accept increasing responsibility for public services with decreasing access to the tax dollars which pay for services. In the worst cases, money does not exist to pay for current obligations. In all cases, state governments are wary about adding services or access which will materially increase their financial outlays. Early consistent emphasis in discussions of eligibility and services must be placed on the cost effectiveness of the health center provider model, as well as on the legitimate role of primary care in reducing the need for more expensive care - which the state also reimburses. Theoretical arguments have little or no effect on practical budgets. A state-specific data set collected on center patients is critical to successful state efforts, as is a health center/SPCA commitment to work cooperatively on state problems at the federal level.

The National Level

Significant movement has occurred at the federal level, and OBRA legislation include a "presumptive eligibility" provision which can be used to expand Medicaid enrollments at health centers. Concern for inappropriate payment of benefits has been a driving force in the complication of the eligibility process, as states pay a heavy penalty for such mistakes. The scarcity of service dollars argues for strict determination of eligibility, but must be balanced by provisions assuring that unnecessary barriers to care will not be erected. Centers should continue to encourage such simplification of eligibility criteria as necessary to assure that appropriate and timely determinations can be made.

Efforts at the national level need to continue in several areas, including:

- Equitability of payment for services, to assure reimbursement of the true cost of providing those services. Previously instituted urban/rural differentials are not reflective of current provider cost data and should be abandoned in favor of accurate cost measurement.
- Encouragement of increased access to care in shortage areas should be a priority, whether those areas are isolated rural communities or urban ghettos. Federal policy should encourage practice in such shortage areas through reimbursement incentives as well as program development. Community and Migrant Health Centers, Rural Health Clinics, and the National Health Service Corps are all worthy examples of such program development and should be accorded high priority.
- Extension of full Medicaid coverage to Medicare populations as a means of increasing access to preventive care and other services necessary to successful treatment of a population which often requires more services at closer time intervals to maintain good health.
- Diversified federal interest in the liability insurance coverage problem which reduces access to obstetrical and other specialty care in isolated areas and for at-risk populations. Accelerated reimbursement for obstetrical care in shortage areas, tort reform, and other such measures should all be seriously reviewed at the federal level.

□

While the current focus is on Medicaid, other issues affecting access and affordability of health care remain important. Copies of NACHC's Rural Health Policy Statement containing current priorities are available on request. Health center efforts at all levels should be directed at assurance of care for those most in need. To that end, we should encourage all federal efforts to develop and sustain access points for primary care, to assure availability of manpower for staffing of those access points, and to encourage, through equitable financing, that adequate care is available to all Americans without regard to financial status.

Senator **Cochran**. Thank you very much for being here and for providing us with this information and completing our record as we inquire about the status of health care services in our State of Mississippi.

Our next witness is Jane Mapp, who is director of Three Rivers Area Agency on Aging in Pontotoc, Mississippi. We appreciate your being here, Jane. Please proceed.

Ms. **Mapp**. Thank you, Senator. I appreciate being asked again. I feel rather inadequate in all this distinguished company today, but as an advocate for the elderly, I will do my best to express our concerns.

Meeting the long-term care needs of a rapidly aging population, rural or urban, is one of the greatest challenges facing our nation. The current approach, which relies primarily on care provided in institutions and which impoverishes older people and their families, fails to provide care in the setting most preferred by older consumers—in their own homes—and also provides this care for only 5 percent of the aging population. Let me say here that I am definitely not against nursing homes. They have their place in the continuum of care, but they do not serve the large portion of the elderly needy.

The 1984 amendments to the Older Americans Act stated that Area Agencies on Aging were to develop a comprehensive and coordinated system of community based long-term care services designed to retain individuals in their homes, thereby deferring unnecessary, costly institutionalization and designed to emphasize the development of client centered case management systems as a component of such services. Great progress has been made toward this end, but it's not enough.

It's wonderful that we're living longer, long enough to enjoy our older years, but also long enough, in some cases, to experience chronic, disabling conditions. And most people are unprepared for the eventuality of long-term illness.

For one thing, there's a lot of misunderstanding about who will pay for nursing care. A recent study by AARP showed that four of five older people assumed that Medicare would pay for long-term care. In fact, it pays less than 2 percent of nursing home costs. The fee, depending on where you live, for nursing home care averages between twenty-two and forty thousand dollars a year. In Mississippi, 42.6 percent of those persons over age 65 have annual income at or below the poverty level, which is approximately six to seven thousand dollars.

The Medicaid Waiver program which Mississippi now has in four counties, and this was touched on this morning, is an excellent tool for helping those elderly who are Medicaid Nursing Home eligible, but wish to stay at home. It needs to be expanded statewide. Dr. Smith mentioned that this morning, and we definitely agree. The return on this money for the state would be tremendous. Hopefully, the state legislature will realize this when we can provide facts and figures for them, and we should be able to do this soon because the program will soon be in effect for approximately two years.

The in-home services that are provided by the Area Agency and service provider agencies such as the Health Department, private home health agencies, the community action agencies and others are extremely important to meeting the needs of the rural elderly. Isolation and loneliness are factors that play heavily on the well-being of older people.

Through the outreach program, the transportation program, and the emergency response systems that most of our counties have, we've been able to alleviate some of this. We also feel that the nutrition sites and senior centers play an important part in keeping numbers of older people well and active longer because of their association with their peers and the various programs that are provided at these centers.

The home delivered meals program is another vital component of the long-term care system, and volunteers are the backbone of this program. However, for the most isolated, rural clients, there is rarely anyone available to deliver this meal. Consequently, there are gaps in service provisions and this is most frustrating for service providers.

The homemaker program is one of the most important programs in the system. However, we presently have in our eight counties that we serve a waiting list of over 500 persons.

We have been told that studies show that the Older Americans Act in-home services programs may not have been as cost effective as hoped as opposed to the cost of nursing home placement. We don't think this is reasonable. ~~One~~ homemaker can serve fifteen to twenty persons. One homemaker costs ten to twelve thousand dollars per year, as opposed to twenty-two to forty thousand for one person in a nursing home. There is no question in the minds of us who work with it everyday that more in-home services is the answer.

Another important program is adult day care. There are only three or four adult day care centers in our whole state. We are fortunate to have one of the best of these in our area. For those families who need to work but have the responsibility of an older family member, this program is a life saver. They can take the older person to the center during the day but have them home at night.

There have been many changes over the past few years. One of the most significant is that the term "working together," or "networking" as we call it now, it was unheard of several years ago. But this new cooperation that we have has enabled agencies in our area, at least, and in most of the state to provide a coordinated system for our older people. Case management has enabled us to get to those most needy, but as in most things, the bottom line is not enough money.

So what can we do about that? We don't feel that the answer is to ask the federal government for everything. The state and local governments have to participate. However, that's not the whole answer either.

We feel that a comprehensive education program concerning private insurance is necessary. Insurance companies are beginning to provide long-term care plans, but most people don't know what they need or how to go about finding out. I just found out recently since I wrote this, as a matter of fact, that our state insurance commissioner does have staff that will go out and help people evaluate the insurance that they have and tell them what they need and how to fill in the gaps with Medicare, so this is a good thing. We had said that we feel like each state needs one person to go around and educate the general public about what is available in the way of long-term care insurance.

Also, the government needs to keep improving and refining the catastrophic illness legislation. There are some good things in it, but there are also some things that could be improved. Let me say now, also, that we endorse the proposal by the National Association of State Units on Aging called Federal Long-Term Care Reform, and I quote from that proposal:

> Federal long-term care insurance should provide its first dollar of benefits in home and community care, which is the least disruptive, least restrictive, and most preferred care, building as it does on supporting family and neighborhood relationships. The benefits of long-term care insurance should be universal and predictable for all older individuals, with uniform cost-sharing based on the ability to pay. Benefits should be tied not to diagnosis or physician fiat but to persons who are impaired to a degree that they require continuous, reliable long-term support to maintain their most ordinary human functions. Regulations and standards should be biased toward the least intrusive home and community based assistance.
>
> Quality assurance needs to be built on an individualized, case-managed system which monitors for achievement of the outcomes sought by the consumer: Comfort, security, dignity.

By supporting the expansion of community care options, federal policy can create a more balanced approach to long-term care resource allocation. We do need to be more responsive to the preferences of older people themselves and that is to receive care in their own homes.

In summary, we recommend these four things: 1) A public education program concerning long-term care insurance; 2) Expansion of the Medicaid Waiver program; 3) A shifting of emphasis from institutionalization to community based home care; and 4) A refining of the catastrophic illness legislation along the lines outlined in "Federal Long-Term Care Reform: A Proposal by the National Association of State Units on Aging."

Thank you again for the opportunity to speak today.

[The prepared statement of Ms. Mapp follows:]

U. S. Senate Subcommittee on Aging
Field Hearing

"Elderly Health Care in Mississippi"

October 20, 1988
North Mississippi Medical Center, Tupelo, Mississippi

Testimony

Jane R. Mapp, Director
Three Rivers Area Agency on Aging
Pontotoc, Mississippi 38863

SERVING: Calhoun, Chickasaw, Itawamba, Lafayette,
Lee, Monroe, Pontotoc and Union Counties

As an advocate for the elderly, I have been asked to discuss the health care needs of the rural elderly in Mississippi.

Meeting the long term care needs of a rapidly aging population, rural or urban, is one of the greatest challenges facing our nation. The current approach, which relies primarily on care provided in institutions and which impoverishes older people and their families, fails to provide care in the setting most preferred by older consumers - in their own homes - and also provides this care for only 5% of the aging population. What about that portion of the other 95% that may need help!

The 1984 amendments to the Older Americans Act stated that Area Agencies on Aging were to develop a comprehensive and coordinated system of community based long term care services designed to retain individuals in their homes, thereby deferring unnecessary, costly institutionalization and designed to emphasize the development of client centered case management systems as a component of such services.

Great progress has been made toward this end but it's not enough.

It's wonderful that we're living longer, long enough to enjoy our older years, but also long enough, in some cases, to experience chronic, disabling conditions. And most people are unprepared for the eventuality of long-term illness.

For one thing, there is a lot of misunderstanding about who will pay for nursing care. A recent study by AARP showed that four of five older people assumed that Medicare would pay for long term care. In fact, it pays less than 2% of nursing home costs. The fee, depending on where you live, for nursing home care averages between $22,000 and $40,000 a year. In Mississippi 42.6% of those persons over age 65 have annual income at or below the poverty level, which is approximately $6,000.

The Medicaid Waiver program which Mississippi now has in four counties is an excellent tool for helping those elderly who are Medicaid Nursing Home eligible, but wish to stay at home. It needs to be expanded state-wide. The return on this money for the state would be tremendous. Hopefully the state legislature will realize this when we can provide facts and figures for them. And we should be able to do that soon, as the program will soon be in effect two years.

The in-home services that are provided by the Area Agency and service provider agencies such as the Health Department, private home health agencies, the community action agencies and others are extremely important to meeting the needs of the rural elderly.

Isolation and loneliness are factors that play heavily on the well being of older people.

Through the outreach program, the transportation program and the emergency response systems that most of our counties have, we've been able to alleviate some of this.

We also feel that the nutrition sites and senior centers play an important part in keeping numbers of older people well and active longer because of their association with their peers and the various programs that are provided at these centers.

The home delivered meals program is another vital component of the LTC system. And volunteers are the backbone of this program. However, for the most isolated, rural clients, there is rarely anyone available to take a meal. Consequently, there are always gaps in service provision and this is most frustrating for service providers.

The Homemaker program is one of the most important programs in the system. However, we presently have in the eight counties we serve,a waiting list of over 500 persons.

We have been told that studies show that the Older Americans Act in-home service programs may not have been as cost effective as hoped as opposed to the cost of nursing home placement. That is not reasonable. One homemaker can serve 15-20 persons. One homemaker costs from 10-12 thousand per year, as opposed to 22-40 thousand for one person in a nursing home. There is no question in the minds of us who work with it every day that more in-home services is the answer. Another important program is Adult Day Care. There are only three or four Day Care Centers in the entire state. We are fortunate to have one of the best in our area. For those families, who need to work but have the resposibility of an older family member, this program is a life saver. They can take the older person to the center during the day but have them home at night.

There have been many changes over the past few years. One of the most significant is that the term "working together", or "networking" as we call it now, was unheard of. This new cooperation has enabled the agencies in this area to provide a coordinated system for our older people. Case Management has enabled us to get to those most needy, but as in most things, the bottom line is not enough money.

So what can we do about that. The answer is not to ask the federal government for more and more. The state and local governments have got to participate. However, this is not the entire answer either.

We feel that a comprehensive education program concerning private insurance is necessary. Insurance companies are beginning to provide LTC plans but most people don't know what they need or how to go about finding out. If each state could have one person to educate the general public about what is available in the way of LTC insurance, tremendous strides could be made.

Also the government needs to keep improving and refining the catastrophic illness legislation. There are some good things in it but there are also some things that could be improved. Let me say now that we endorse the proposal by the National Association of State Units on Aging called Federal LTC Reform and I quote from that proposal.

"Federal long term care insurance should provide its first dollar of benefit in home and community care which is the least disruptive, least restrictive and most preferred care, building as it does on supportive family and neighborhood relationships. The benefits of long term care insurance should be universal and predictable for all older individuals, with uniform cost-sharing based on the ability to pay. Benefits should be tied not to diagnosis or physician fiat but to persons who are impaired to a degree that they require continuous, reliable long term support to maintain their most ordinary human functions. Regulations and standards should be biased toward the least intrusive, home and community based assistance.

"Quality assurance needs to be built on an individualized, case-managed system which monitors for achievement of the outcomes sought by the consumer: comfort, security, dignity."

By supporting the expansion of community care options, federal policy can create a more balanced approach to long term care resource allocation. We do need to be more responsive to the preferences of older people themselves and that is to receive care in their own home.

In summary then, we recommend:

1. A public education program concerning LTC insurance,
2. expansion of the Medicaid Waiver program,
3. a shifting of emphasis from instutionalization to community based home care,
4. a refining of the catastrophic illness legislation along the line outlined in "Federal LTC Reform: a proposal by the National Association of State Units on Aging."

Thank you for the opportunity to speak on behalf of those we serve.

Senator **Cochran**. Thank you, Jane Mapp, for being here and being a spokesperson for those who are served by our health care system programs in our state.

Dr. Ames Tryon is our final witness in this panel. He is director of the Geriatric Center at the University of Mississippi Medical Center in Jackson.

Dr. **Tyron**. Thank you, Senator Cochran. I'm delighted to be here to be able to make a few remarks on behalf of the educational community. I feel sort of like a fish out of water here. Most testimony has been directed toward reimbursement and service delivery. No one has been addressing educational issues. We think education is pretty important and I will speak in this area.

In addition to being on the Medical Center and a professor there, I'm also on the Governor's Council on Aging and also on the Technical Advisory Committee on Long-Term Care for the Medicaid Commission. So I have many opportunities to work with people throughout the state in various capacities.

I might say something about the Geriatric Center. It is a joint venture between the Medical Center and the Bureau of Health Professions of the Health Resources and Services Administration of the Department of Health and Human Services. Our Geriatric Center is one of thirty-three similar projects that have been funded in approximately twenty states. We're entering our fourth year of funding on a five-year cycle, and we have received well over a million dollars.

I might also parenthetically mention, somebody talked about the Robert Wood Johnson Foundation. I had the opportunity to serve as a Robert Wood Johnson health policy fellow and worked in the office of Phil Gramm, one of your colleagues, when we was in the House and had a great interest in Medicare and long-term care.

The Geriatric Center has several goals that were developed in response to a national need for more and better trained health professionals to serve the rapidly expanding elderly population. Funds were appropriated by Congress to help medical centers such as ours build educational programs and provide learning opportunities for physicians, nurses, dentists, social workers, and a large number of other health and social professionals. The long range goal of this initiative is to establish an ongoing educational programs to help all service providers keep abreast of new knowledge and developments.

Our center is focusing on several areas including faculty development in the institutions of higher learning, training for health and social service practitioners throughout the state, and developing resources for use by providers and elderly citizens. Our long range goal is to become a permanent training center and research center for this state that is dedicated to the improvement of the quality of life for the elderly.

As far as the needs are concerned, the population of this state and the nation, as most of us know is undergoing an unprecedented aging phenomenon. We're really becoming a nation of middle-aged and elderly persons. As health care technology improves and changing lifestyles are geared more toward health promotion, the majority of people in this country will be living beyond 80 years of age.

As the population ages, we've already seen and are witnessing a dramatic shift in the epidemiological patterns away from acute episodic disease, which is on the decline, toward chronic disease. And many of us know the characteristics of chronic disease. Chronic diseases are long-term. They have an uncertain course. They involve discomfort, pain, disability and restricted activity. They multiply themselves. They intrude into the lives of others, and they require a coordinated management approach, which I'll make a few remarks about in a moment.

Our current health and social support systems are really not equipped to handle an aging population. The following problems already exist and are getting worse, and we've already heard about one of them and that's the relative shortage of primary care physicians who are the mainstay of the health care system for the elderly. In addition, many health care facilities really are not oriented toward chronic disease management due to a variety of historical reasons plus the fact that health care financing is primarily directed toward acute care.

There is also another issue that we run into all the time. There's really a lack of coordination among various agencies and organizations that have programs that would benefit the elderly. In some cases, there is direct competition among these entities. And fourth, and the one that we're most concerned about, is that the majority of persons who provide direct service to the elderly lack sufficient training in geriatrics and gerontology.

So I'd like to briefly review these problems and then suggest a few solutions from our perspective at the Medical Center. The problem of shortage of primary care physicians has been addressed many times by many people, and I won't even dwell on that at all. I think we've got adequate information in that area except just to say that we're very interested in providing training opportunities for these physicians and, in fact, are going to establish a training program to help primary care physicians take the added qualifications examinations which are being offered now to internists and primary care physicians who wish to be identified as having geriatric competencies. And we're developing an educational program for that.

As far as the hospitals are concerned, most people have talked about the issues. I really don't think we need to make too many more remarks about them. All the problems have been outlined, and I don't know how many solutions have been proposed.

The third issue and the fourth issue are the ones I want to dwell on. The Federal, State and local governments have authorized and appropriated funds to support a large number of programs for the elderly. The eligibility for these benefits include age related entitlements and income means-tested programs. Although many programs exist, there doesn't appear to be any formal linkage between health care programs and social service programs. We see that all the time in this state. Our observation suggests there's a fragmentation and lack of coordination among all of these entities including area agencies, Health Departments, physicians' offices, hospitals, nursing homes, and educational institutions. This is a major problem for us.

Each entity appears to receive funding from different sources, has different eligibility criteria and offers a different array of services. In some instances, the services offered under each of the separate umbrellas is the same or similar.

I've got an exhibit that I think I included in our testimony to you which shows the various funding agencies and how they cross over. There appears to be a relatively uncoordinated maze of services that are available, and they're creating an environment where gaining access is really a challenge for elderly clients and their providers.

There are multiple entry points into the health and social service network, and oftentimes, they lead down in solitary pathways. In this type of environment, access is a function of knowledge really on the part of the elderly person or how to access the service. And in many instances, one group or agency does not know everything that is available. When the lack of coordination is superimposed by a competitive attitude surrounding the scarce resource base, the elderly become, I think, more confused and access is even more limited.

Finally, the relative lack of formal training in geriatrics and gerontology on the part of many service providers is not very comforting. Very few programs exist in our professional schools which address the issues of aging and prepare people for careers in geriatrics or gerontology. Furthermore, employment and in institutions and agencies that implement programs for the elderly is often not predicated on appropriate training and certification in geriatrics and gerontology. We would also add the fact that even when training programs are available they tend to prepare people in discipline oriented isolation. The elderly are more likely to benefit from a multidisciplinary or interdisciplinary approach.

So our solutions from an educational perspective, and that's all I'll really confine them to, is first, I think we would like to see more coordination among all publicly funded health and social programs that are designed to benefit the elderly. I would like to see duplication overlapping these programs eliminated or at least coordinated through centralized agencies perhaps at the state level. It would also be ideal to explore ways that the health and social service sectors could be formed into an interdisciplinary network, rather than operating in isolation, which is often the case.

Secondly, of course, we'll put in a plug. We think federal support for Geriatric Education Centers should be continued and expanded, and I notice in one of the Senate bills there is a continued support and some expansion for the Geriatric Education Center concepts. We believe that this federal initiative has more potential for improving health care for the elderly than any other initiative that has been developed in recent years.

Given the aging of the population and the tremendous increase in chronic disease, there's a great need for more programs that focus on multidisciplinary, interdisciplinary and now the new word is transdisciplinary education and training. Geriatric Education Centers really provide a mechanism now for faculty and providers from various disciplines to learn together and work together, and most of them are interdisciplinary oriented across the country.

Geriatric Education Centers help create an environment of mutual cooperation and interdisciplinary communication. Eventually, this is going to lead to community based efforts, and our center one of the leaders really in attempting to promote interdisciplinary training.

Over the next two years, we plan to develop many programs and I have a folder here, which is really my Exhibit B that you didn't get in the fax machine. We've developed several models and we think they're going to have national significance. We are designing now to be implemented sometime in the future a statewide training network where we're going to carry all the programs and activities and resources of the center out into the community rather confining most of our activities to the medical center where we've been for the first three years building a solid base.

Finally, just a few remarks. I think programs that are funded and are regulated by federal and state governments should contain regulations and criteria, and some of these are creeping into the law now we're seeing, requiring all providers who receive funds and support from these services to be competent in working with the chronically ill and elderly.

During the past few years, each occupational group that serves the elderly has begun to delineate specific knowledge and skills that should be possessed by persons working with the elderly. Many of these occupations are at a point where they specifically state what they expect from their colleagues. Several of you have established formal training programs and/or qualifying examinations. This trend should be encouraged and supported whenever possible.

The three pronged approach I have outlined above would greatly enhance the ability of the elderly to remain functionally independent throughout a lifetime. Elimination of duplication and better coordination among aged benefit programs would make services more accessible and cost effective. Support for more interdisciplinary educational efforts such as the Geriatric Educational Center would help create an environment of mutual cooperation and coordination. Regulating efforts that mandated formal training and demonstrated competencies would also assure the elderly that there receiving help and care from skilled and competent professionals.

That concludes my remarks, and I'd like to thank you for letting me be here.

[The prepared statement of Dr. Tyron follows:]

DRAFT

STATEMENT FOR HEARING OF U.S. SENATE SUBCOMITTEE ON AGING
"ELDERLY HEALTH CARE IN MISSISSIPPI"

Introduction Remedies:

My name is Ames Tryon and I am a Professor at the University of Mississippi Medical Center and Executive Director of The Mississippi Geriatric Education Center. I am also a member of The Governors Council on Aging for the State of Mississippi and serve on the Technical Advisory Committee on Long Term Care for The Medicaid Commission. The Geriatric Center is a joint venture between the Medical Center and the Bureau of Health Professions of the Health Resources and Services Administration at the Department of Health and Human Services. Our Geriatric Education Center is one of 33 similar projects that have been funded in 30 states.

The Geriatric Education Center has several goals that were developed in response to a national need for more and better trained health professionals to serve our rapidly expanding elderly population. Funds were appropriated by Congress to help Medical Centers such as ours build educational programs that provide learning opportunities for physicians, nurses, dentists, social workers and a large number of other health and social serice providers who work with the elderly. The long range goal of this initiative is to establish on going educational programs that will help all service providers to keep abreast of new knowledge and developments.

Our center is focusing on several areas including faculty development in our institutions of higher learning, training for all health and social service practitioners throughout the state, developing resources for use by providers and elderly citizens and networking activities to help coordinate training and service delivery to elderly Mississippians. Our long range goal is to develop a permanent education and training center dedicated to the improvement of the the quality of life for the elderly.

The Needs:

The population of this state and the nation is aging at an unprecedented rate. We are becoming a nation of middle aged and elderly persons. Continued improvements in health care technology and changing life styles are creating a situation where the majority of persons will live beyond 80 years of age. As the population ages there will be a dramatic shift in epidemiological patterns away from acute episodic disease toward chronic disease. The characteristics of chronic disease are:

(1) They are long Term.
(2) Their course is uncertain.
(3) They involve discomfort, pain, disability and restricted activity.
(4) They multiply themselves.
(5) The intrude into the lives of others.
(6) They require a coordinated management approach.

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Our current health and social support systems are not equipped to handle the aging of our population. The following problems already exist and are getting worse:

(1) There is a relative shortage of primary care physicians in many areas of the state.
(2) Most health care facilities are not oriented toward chronic disease management due to a variety of historical reasons and the fact that health care financing is primarily directed toward acute care.
(3) There is a lack of coordination among various agencies and organizations that have programs that would benefit the elderly. In some cases there is direct competition among these entities.
(4) The majority of persons who provide direct services to the elderly lack sufficient training in geriatrics and gerontology.

I would like to briefly review each of these problems and then suggest some solutions:

First, the relative shortage of primary care physicians is a local and national problem. The family physician and general internist are an essential part of the future of health care for the elderly. Older persons are often faced with having to direct their own care plans and select specialists on the basis of perceived symptoms and geographic accessibility. The elderly would benefit greatly from having more primary care physicians who can help them coordinate a health care program.

Secondly, hospitals were established primarily as places where acutely ill persons were housed and treated. After Medicare was established hospitals flourished and expanded. The rural hospitals also benefitted from early Medicare financing. With the adoption of PPS financing many hospitals have been unable to maintain occupancy rates that assure financial stability. Many hospitals are attempting to expand their traditional base by offering chronic and long term care services. Unfortunately the financing system does not reward these efforts. Hospitals are still primarily acute disease management facilities.

Thirdly, federal, state and local governments have authorized and appropriated funds to support a large number of programs for the elderly. Eligibility for benefits from these programs include age related entitlements and income means-tested programs. Although many programs exit there does not appear to be any formal linkage between health care programs and social service programs. Our observations suggest that there is fragmentation and a lack of coordination among Area Agencies on Aging, Health Departments, physicians offices, hospitals, nursing homes, educational institutions and various groups and agencies that have programs that could benefit elderly.

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Each entity receives funding from different sources, has different eligibility criteria and offer a different array of services. In some instances the services offered under each of the separate umbrellas is the same or similar (see exhibit A). This relatively uncoordinated maize of services that are available to the elderly creates an environment where gaining access becomes a challenge for clients and providers. There are multiple entry points into the health and social service network that often lead down solitary pathways.

In this type of environment access is not only a function of knowledge on the part of the elderly person but knowledge on the part of the providers and caregivers. In many instances one group or agency does not know everything that is available. When the lack of coordination is superimposed by the competitive attitude that surrounds a scarce resource base, the elderly are even more confused and access is even more limited.

Finally, the relative lack of formal training in geratrics & gerontology on the part of many service providers is not very comforting. Very few programs exist in our professional schools which address the issues of aging and prepare people for careers in geriatrics or gerontology. Furthermore, employment in institutions and agencies that implement programs for the elderly is not predicated on appropriate training and certification in geriatrics and gerontology. We would also add the fact that even when training programs are available they tend to prepare people in discipline oriented isolation. The elderly are more likely to benefit from a multidisciplinary or interdisciplinary approach.

Solutions:

The solutions for each of the above stated problems are varied and complex. Many of those testifying at this hearing have already made several useful suggestions on manpower and health care financing. Therefore I will confine my remarks to the areas of education, training and networking.

First, I would like to suggest that more effort needs to be made for coordination of all publically funded health and social programs that are designed to benefit the elderly. I would like to see the duplication and overlapping of these programs eliminated or at least coordinated through a centralized state agency. It would also be ideal to explore ways that the health and social service sectors could be formed into an interdisciplinary network.

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Secondly, Federal support for The Geriatric Education Centers should be continued and expanded. This Federal initiative has more potential for improving health care for the elderly than any other initiative that has been developed in recent years. Given the aging of the population and the tremendous increase in chronic disease there is a great need for more programs that focus on multidisciplinary, interdisciplinary and transdisciplinary education and training. The Geriatric Education Center provide a mechanism for faculty and providers from various disciplines to learn together and work together. The Geriatric Education Centers help create an environment of mutual cooperation and interdisciplinary communication. Eventually this will lead to community based coordinated efforts.

Our Geriatric Education Center is one of the leaders in interdisciplinary training. We have developed several models that could have national significance and have designed a statewide training network that could have a far reaching impact on services to the elderly (See Exhibit B for the Geriatric Education Center Materials).

Finally, programs that are funded or regulated by Federal and State Governments should contain regulations and criteria requiring all providers who receive funds or support from these sources to be competent in working with chronically ill elderly. During the past few years each occupational group that serves the elderly has delineated specific knowledge and skills that sould be possessed by persons working with the elderly. Many occupations are at a point where they can specifically state what they expect from their colleagues. Several have established formal training programs and/or qualifying examinations, this trend should be encouraged and supported.

The three pronged approach outlined above would greatly enhance the ability of elderly persons to remain functionally independent throughout a lifetime. Elimination of duplication and better coordination among aged benefit programs would make services more accessible and cost effective. Support for more interdisciplinary educational efforts such as The Geriatric Education Center would help create an environment of mutual cooperation and coordination. Regulating efforts that mandated formal training and demonstrated competencies would assure the elderly that they are receiving help and care from skilled professionals.

Senator COCHRAN. Thank you, Dr. Tyron. I'm told that we have passed this year a bill entitled the Health Professions Education Bill that includes funding or authorization for funding of Geriatric Education Centers. I don't know whether that word is filtered out, but they just passed the bill. And it is a reauthorization of existing legislation, but it does provide more money for Geriatric Education Centers. So I hope that will prove to be helpful to the effort that we're making in this important area.

I appreciate so much this panel making us think about some of the challenges that we still have out there, that are very complex to deal with and, particularly, in our smaller towns and in our rural communities helping to meet the needs of our elderly citizens for health care.

I know that one problem that has been brought up time and again today is attracting physicians to smaller towns and rural communities. And I thought the testimony of both Dr. Russell and Dr. Hill very illuminating in this area from their personal experiences.

I think Dr. Hill pointed out that funding is needed to support family practice training in some of our smaller towns and that that might be a way to help deal with the problem. I think he mentioned towns such as Tupelo, Greenville, Pascagoula, others where training really doesn't occur now but should occur to help meet these needs.

I wonder in such a program whether or not this money would go to university medical centers for residents training in these areas, or how would you envision this training to be structured?

Dr. HILL. I would envision it to be university affiliated and community based, and about 65 percent of the residency programs now are like that. There are fewer community based residence programs. It would have to be, I think, a university affiliated and community based program. The reason for that is that it is well shown now the residents settle within a 50-mile radius or large majority of where they finish their residency programs and that would be the reasoning behind that. Right now we train them all in Jackson so they settle within a 50-mile radius of Jackson or they move out of the state.

Senator COCHRAN. One thing that was mentioned in your testimony was the Senior Care Program which is a new program of the Mississippi State Medical Association, that's very interesting, to work in conjunction with the Mississippi Council on Aging and in an effort to enable low income people to get better attention. I wonder, though, if this is going to be limited to physicians who accept Medicare assignments? It won't be?

Dr. HILL. No.

Senator COCHRAN. Well, I misunderstood then.

Dr. HILL. We're asking physicians to participate to accept assignment. We have no mandatory assignment.

Senator COCHRAN. That would encourage probably more physicians to accept Medicare assignment. That's interesting to me because I think in one of our earlier witness' testimony we heard that there was just about a third, I guess, of the physicians in state who will accept Medicare assignment.

Dr. **Hill**. Thirty-three percent. We've gotten a better response from that from the general physicians in the three areas that we've asked to participate. Forty-two percent of the Golden Triangle area responded positively. Nobody responded negatively, so I think that means we'll get a better response once the program——

Senator **Cochran**. Yes.

Dr. **Hill**. In the North Delta area about a 38 percent response, which is more than the people that are accepting assignment there now. Of course, many, many physicians who aren't participating, accepting assignment, as you well know—we think about 75 percent accept assignment on a case by case basis and most of that is just about everybody, so we think it's a good program.

The problem is we're talking about somewhere between, and I think these figures are fairly accurate, in the North Delta area and the Golden Triangle area we're talking about 20 thousand recipients of care that will meet the criteria will be indigent Medicare. We're talking about a substantial number of people in just these two areas. If you go statewide, I don't know what the figure is, but it's substantial. And a lot of these elderly people are having to be very conservative because a lot of them like to pay their bills and if they can't pay, they won't go. Access is a problem, also.

Senator **Cochran**. What's your reaction to that question, Dr. Hill's discussion of that Senior Care Program and the acceptance of Medicare assignments?

Dr. **Russell**. My clinic accepts Medicare assignments and has now for about two years. We didn't at one time. I'm very seriously considering not accepting it because of the very pitiful way that the program is run.

Senator **Cochran**. Is it mostly the paperwork burden?

Dr. **Russell**. It's mostly the unfairness and the disgust that it adheres. For instance, all the Medicare recipients are not poor people. In my hometown, as you well know, having married a girl from my county, a lot of the women in our town are the wealthiest people in our county and are left widows of very rich men who died before they died.

We can't charge them anything above sixteen dollars and ten cents for an office call. Likewise, we can't do a lot of lab work they want to have done under Medicare because Medicare won't cover it. So it's their advantage if we don't accept Medicare, and they can obtain the health care they want. And so I don't know. I'm seriously considering at the end of this year not accepting Medicare anymore, but I don't really want to do that.

Senator **Cochran**. What's your reaction to the senior care plan Ed Hill talked about?

Dr. **Russell**. I thought it was a very interesting plan worth looking at.

Senator **Cochran**. Maybe giving it a try?

Dr. **Russell**. Certainly.

Senator **Cochran**. Well, I think it is interesting sounding and we ought to encourage this kind of thing, I think, to develop. I really feel like we sometimes get a better answer when we work at the local and state level to develop our own answers than waiting on somebody in Washington to tell us what we have to do, and that is not necessarily the best way to go about solving problems sometimes.

One thing that has been a decision of the federal government that Thad Bridges talked about the practical impact of and that is the availability of physicians for the community health centers. I'm assuming that these federally hired physicians that you described that are being phased out, work out of the health centers?

Mr. **Bridges**. Right.

Senator **Cochran**. We're going to be having fewer and fewer of them assigned to the health centers in Mississippi in the future. Is that correct?

Mr. **Bridges**. That's correct, Senator. We are primarily based with the National Health Service Corps of Physicians.

Senator **Cochran**. What do you think about the loan program? They're calling it a medical school loan that National Service Corps has now that if a physician agrees to serve for a given period of time in a health manpower shortage area, you're forgiven part of the loan? Would you comment on that new loan repayment program? Do you see that as a possibility for helping take up the slack?

Mr. **Bridges**. We're using that, Senator, as one of our recruiting tools for some of the doctors who are in the amnesty process in terms of coming back to live out their obligations. You understand how that works in terms of a physician that is educated on National Health Service Corps with a four year scholarship, and what they're saying is for those physicians who did not go to the underserved areas that they were requested before, that they are given an opportunity to come back in now and to use their loan repayment program.

But at the same time, we feel like this should be extended to physicians that have lived out that obligation and still owe loans on their education. And we could use that and extend that bill beyond that, that probably would help us retain some of those physicians in the local area.

Senator **Cochran**. In Vicksburg in your medical center, tell us a little bit about the set-up there that you have. What kind of staff do you have?

Mr. **Bridges**. Right now, Senator, we have 3.5 providers. That's three physicians and one nurse practitioner. Our medical director is an internist. We have a family practitioner, and we have a nutritionist. We just lost the service of our obstetrician and another internist because their obligation was up and they moved out of state and they moved on to a higher paying job. And you really can't blame them for that because we're not funded to compete with the private sector nor create the incentive that we can try to retain those physicians in our community health centers. That's one of the things that we're working on and hope to be meeting soon in trying to create an incentive program to retain the physicians in local communities. That's a big problem.

Senator **Cochran**. I was interested in the observations Jane Mapp was making about insurance coverage for long-term care, and that is something that I think we're going to be trying to encourage and trying to acquaint more and more people with as an option.

I wonder whether or not there has been any effort to provide coverage by insurance companies for any of these other services that are available but sometimes out of reach financially, adult day care, things of that kind? I would just wonder whether or not maybe in the future a whole package of benefits might be included in an insurance policy for those who are looking to retirement years?

Ms. **Mapp**. I think they are working on that, several companies are, and we find the problem with most of the people we deal with, they may have insurance. They may have two or three policies, but they don't cover what they really need and sometimes they overlap each other and so that's one reason we felt like if there were a person that all they did was go to senior centers or elderly church groups or whatever and explain what Medicare and Medicaid, if they have that, really covers and what they need to fill the gaps and maybe work with the insurance companies to get these plans together that will cover what the older person needs.

Senator **Cochran**. I was curious when I heard Dr. Tyron mention the access into the pipeline for elderly services and health services and that kind of thing sometimes leading down a solitary path. It seems to me that—and I don't want to start an argument necessarily between the panel members—but it seems to me that throughout my experience here in the state in working with elderly programs and the House Select Committee on Aging and other experiences that I've had that our area agencies and our other service providers in the state have done a pretty good job of acquainting the elderly people in our state of the services that are available. I wonder what your reaction to that is, or do we have more of a problem than I expected that we have?

Ms. **Mapp**. Well, you know, you can always do a better job than you're doing. We feel like we're doing better than we have done in the past. The case management program has helped considerably. And I do feel that agencies are working together better now than they were in the past.

In the case management program and the Medicaid Waiver program, you almost have to work together to get the job done. And we feel like that we are doing a better job. A lot of times what happens is you'll find somebody that says, well, I didn't know there was such a thing as an Area Agency on Aging, but the reason is they haven't needed it. When they start looking for something, then somebody will say well, you should call the Area Agency.

We do have, in fact, all the ten Area Agencies in Mississippi have toll free numbers for their area that anybody can call in. And we feel like that we're the one place that people should call because if we can't provide the service, we can at least tell you where to go to get it or help you in some way.

Senator **Cochran**. Well, I think the four counties that are having this waiver experiment, experience offers promise, too, doesn't it?

Ms. **Mapp**. Oh, definitely, not only for the older people, but for the economy of the state. I mean that money's going to come in to the state and turn over several times before it leaves again and, also, we feel like it will help in reducing the nursing home bed crunch because a lot of those people are going to stay in their homes rather than go to the nursing home.

Another thing, too, is if we had a system, whereas a person going into a nursing home had to meet criteria not just because they wanted to go or because they felt like they needed to go, that it would keep some people out that don't really need to be there. Now, a lot of times the family will say they're tired of fooling with this old person; let's put them in the nursing home. And they don't really need to be there, and they take up a bed that somebody that really needs to be there could have.

Senator COCHRAN. Well, I appreciate all of you participating in this panel, and I think now what we will do is to hear from our federal agency resource person who is here today, Mr. Jeff Human, who is director of the Office of Rural Health Policy of the Health Resources and Services Administration from Washington. Thank you all for being here. We appreciate it very much.

What we hope to be able to do in this final session of the hearing is get a critique or response from a representative of the Health Resources and Services Administration. Mr. Jeffery Human, who has been here throughout our hearing and has heard all of the testimony and the questions and answers that we've had presented, will give us sort of an overview of his impressions of some of the problems that we've identified, some of the policy solutions that we may have not thought about. So Jeff, whatever thoughts you have and then we can discuss your reaction to the hearing.

STATEMENT OF JEFFERY HUMAN, DIRECTOR, OFFICE OF RURAL HEALTH POLICY, HEALTH RESOURCES AND SERVICES ADMINISTRATION, WASHINGTON, DC

Mr. HUMAN. Senator, thank you very much. Since our department of Health and Human Services was not asked formally to testify, I don't have formal testimony cleared by our department. I do want to respond to your request, however, because I know how important rural health care and health care for the aged are for Secretary Bowen, the secretary of our department. The Medicare catastrophic bill that was passed by the Congress earlier was strongly advocated from the beginning by Secretary Bowen, and I think it's an important part of the client record and care for the aged in rural health care that he has established. So I'm going to try to reflect departmental policy in my comments as well as the views I learned from rural citizens all over the country on the subjects of rural health care, many of which echo very strongly what we've heard so far today.

Let me begin by saying that I think it's important to consider that rural health is not a federal problem that requires a federal solution to be sure the federal policies must be a part of the solution, but we also, as many of the other speakers have indicated, have to look to states and we have to look to communities, as well, in solving these problems.

I'd like also to say by way of introduction that a great many senators and congressmen currently are making statements and formulating proposals in rural health and the need for changes. Not nearly as often are these senators and congressmen going home to their constituents in formal hearings like this one and trying to develop solutions by listening to the problems and recommendations of the people who live with health care delivery on the front lines. So I want to join others in this room who have already congratulated you in holding this hearing here in Mississippi.

I also want to congratulate the witnesses today for having documented and illuminating the problems of access to rural health care from the perspectives of the patients, as well as from the perspectives of the institutions themselves that are trying to survive.

Senator, we share your concerns about the financial stability of rural hospitals and the chronic shortage of health professionals in many rural communities throughout the country. These are the two highest priorities we have set within our own Office of Rural Health Policy. In looking at these problems, we are mindful of the fact that the percentage of elderly Americans living in rural communities is high and has been growing. We followed the interest and the commitment of this committee to the preservation of access to care for these individuals.

There are two principal problems that we have to deal with when we are talking about rural health. Those are the problems of hard times for rural communities in maintaining viable hospitals and in maintaining medical practices. And this is true all across the country, not just in Mississippi.

If we take a look at the question first of hospitals, we hear the most about the Medicare prospective payment system, which was put into place in 1983. I think one thing that should be said at the beginning is that no one anticipated at that point that the effect of that system would be what it has been. Our department advocated a single rate for urban and rural hospitals in the beginning of the process, but in the end, the bill that passed provided for a lower rate for rural hospitals than for urban rates and later as the system was complicated, the rates went up even higher for urban areas in relation to rural areas. That has been a problem and it has been suggested that it is the only problem, which I think is really not correct. Because if we look at rural hospitals, there are at least two other factors I think that we have to consider strongly.

The second problem is that admissions have been falling in rural hospitals throughout this decade. Hospitals in rural areas have been depopulating. In some areas, such as the upper Midwest, population shifts have a great deal to do with what is happening. People are leaving rural towns because of the economic problems that are occurring in many parts of the country.

But in many other areas, physicians are referring patients to larger urban hospitals rather than to local community hospitals, and in those same kinds of areas where physicians are trying to keep referring patients to the community hospitals, the patients themselves are asking that they be referred to the larger urban hospitals. And I want to come back to that a little bit later in the presentation as to how we might deal with that.

A third reason that has certainly been mentioned a lot this morning is that the rural economies have been in trouble during this decade. The percentage of patients who have been unable to pay their bills has been going up and that burden, in most states, has fallen upon the rural hospitals themselves.

I think we have to address all three problems if we are to regain viability for rural hospitals—The problem of equity in Medicare reimbursement, the problem falling of admissions and the problem of uncompensated care. I think as we look to regain the viability of rural hospitals, we have to look not only to the federal government but the state governments and the communities.

Similarly, as we look at the problems of physicians, we find that the problems are very similar. A recent study performed at the University of Wisconsin showed that in small rural communities between 1975 and 1985, physician to population ratio has grown at a rate less than half as fast as the nation as a whole. Moreover, small rural communities continued in 1985 to have physician to population ratios less than one-third of national rates. In rural areas there were fifty-three physicians for every one hundred thousand people versus a hundred and sixty-three physicians for every one hundred thousand people in the nation as a whole.

We are especially concerned that there is an apparent shortage of physicians in family practice and primary care. That shortage has profound implications for rural areas because there are fewer primary care physicians per capita there than there are in nonrural areas.

We also see when we look at Medicare again that under Part B of Medicare, rural physicians are reimbursed in most areas of the country at a substantially lower rate than urban physicians. This provides a powerful disincentive for physicians to settle in rural areas, and it is part of the Medicare problem that I think we have to address. These then are the problems as they might be outlined as we see them nationally, at any rate.

Now, if we take a look at the solutions and begin with the federal government this has been a Congress that has become increasingly rural health oriented. We look at the Congress. You yourself, Senator, are part of a Senate Rural Health Caucus that has sixty of the one hundred members of the Senate of the United States. The House Coalition on Rural Health Care has been slower to develop, but it already has about a hundred members of the four hundred thirty-five members of the House of Representatives. In part because of the caucus and the coalition there have been improvements, and I think everyone in the room needs to look to these improvements as signs of progress that have begun to occur during really only the last few years and that have the potential to persist over the next several years.

The last two omnibus reconciliation bills that have been passed by the Congress have provided higher updates for rural hospitals than for urban hospitals, and they have provided improvements for rural hospitals as well, and the establishment and then the expansion of the swing bed program to hospitals that have up to a hundred beds, as well as other improvements that have been made.

The Congress has just finished passing an appropriations bill that includes nine million dollars for what is called a Health Care Transition Bill, a bill that was sponsored by Senator Durenberger of Minnesota. Under that bill, rural hospitals can receive grants of up to 50 thousand dollars per year for up to two years to do some strategic planning with their communities to try to determine what problems they have and how they ought to address individually those problems. The bill also provides funding in the second year for implementation of the strategic planning process that has gone on in the first year.

When we look at the executive branch of the government, we have heard from one speaker or another about really almost all of the programs that I would mention that have been important in rural areas that we have had for the last several years.

The National Health Service Corps has been converted from a program that paid for scholarships for medical students to a program that repays loans for medical students. That program has been funded at a level to provide nationwide for the assignment of 200 new physicians and 300 new nurses next year and those placements will be made predominantly, if not exclusively, in rural areas.

Community and migrant health centers across the country serve more than three million rural Americans. Under this program, financial assistance is provided to community group practices in order that they may hire physicians in areas that do not have the economic base in which physicians would be able to provide care, and since the federal grant is provided for the people who cannot afford care, then a sliding fee scale is used so that those who can pay the full fee do so and those who cannot pay at a discounted rate because of the federal grant.

In Mississippi, we have a number of community and migrant health centers. The very first rural community health center was in Mount Bayou and the most recent community and mental health centers have also been in the State of Mississippi, as well, in which we have provided health care in Tunica County for the first time and in Ashland and in Burnsville.

Let me read just briefly the places where community and migrant health centers provide care in the state and this isn't even a full list, but it's a partial list. Jackson, Iuka, Belzoni, Vicksburg, Tylertown, Biloxi, Gulfport, Grant, Carthage, Yazoo City, Fayette, Port Gibson, Laurel, Leakesville, Gloster, Meridian, Mendenhall, Prentiss, Sebastopol, New Augusta, Sumrall, Shubuta, Clarksdale, Mount Bayou, Mantachie, Smithville, Tremont, and Houlka.

We have grants for medical education nationally and more than a million dollars is provided to Mississippi each year through that program. We have area health education centers in which medical schools and communities work together to place students in our rural communities. There is not an area health education center in Mississippi at this time.

One act that is attracting a lot of attention that is administered by the Health Care Financing Administration is the Rural Health Clinics Act. That act was passed in 1977. The original law allows for Medicare and Medicaid reimbursement to rural health clinics for services provided by nurse practitioners and physicians assistants even when the services are not provided under the direct supervision of a physician.

An amendment to the law enacted last year raises the basic medical and counter rate for rural health clinics from about thirty-two dollars to forty-six dollars. We hope this will encourage the establishment of more such clinics in rural under-served areas around the country because under the Rural Health Clinic Act, the reimbursement tends to be higher and as a result, you get greater stabilization of care in rural areas. And, of course, we also approve of the idea that physician extenders are used so that communities may be reached that are small and that may never be able to attract and retain physicians.

Senator COCHRAN. Are there any such rural clinics in Mississippi under that act? Do you know?

Mr. HUMAN. I did not bring a list with me. Perhaps someone here can indicate——

Unidentified member of the audience. There are about four that I know of.

Mr. HUMAN. Nationwide there are six hundred. In some states, such as Pennsylvania, virtually all of the federally supported rural health community health centers are eligible under that act and in other states, it's not the case.

Senator COCHRAN. You mentioned the training assistance that is available under federal statute now and said that there were no funds being made available in Mississippi. Is this the rural training?

Mr. HUMAN. This is the area health education centers.

Senator COCHRAN. Would this be the kind of thing Dr. Hill was suggesting where we make available training opportunities in towns such as Tupelo, Greenville, Hattiesburg?

Mr. HUMAN. That's correct, sir.

Senator COCHRAN. That could be done under existing statute, but we don't have any funds in Mississippi targeted for that; is that right?

Mr. HUMAN. That is correct.

Senator COCHRAN. If we applied for some, how about the chances of our getting some approved?

Mr. HUMAN. I honestly don't know what the situation is. That program has tended to be level funded during the last few years, and yet, there is a limit on the number of years that you can receive funds under the program. So when old programs leave, new programs can come in, and I would expect that there would be a possibility there. How good, I don't know.

Senator COCHRAN. I think it may be a good idea for us to put our name in the pot, and I'll help make sure that the note is in there. We'll work on getting some money for our state for that program. That sounds like a good opportunity for us.

Mr. HUMAN. Certainly Mississippi educational institutions have participated in receiving federal assistance for health professions education for a number of years. I mentioned some of the ones. I looked through the book before I came at those that do receive federal assistance, and they include the Mississippi University for Women in Columbus; Jackson State; Coahoma Junior College; the University of Mississippi Medical Center; Mississippi State; Tougaloo College; the University of Mississippi.

I would mention now in addition to the federal government that we are making some progress in the states, as well. I think one of the places in which, if we talk about hospitals, and what states are doing, that one of the places that has received the most attention in recent months in Montana.

The Montana Legislature at the urging of the Montana Hospital Association has recognized the special problems, they're very small in failing, isolated late rural facilities and has taken an action. That action is to create a downsizing option that was previously unavailable. The legislature has created a new kind of health care service known as the medical assistance facility.

A medical assistance facility is a health facility that 1) provides in-patient care to ill or injured patients prior to their transportation to a hospital or provides in-patient care to persons needing that care for a period no longer than four days; and 2) a medical assistance facility either is located in a county with fewer than six residents per square mile or is located more than thirty-five miles from the nearest hospitals.

Now, that is the definition that does not exclude a lot of facilities in Montana, and it's a definition that I'm sure would be rewritten in other states that were following this model.

Medical assistance facilities must meet state licensure and certification requirements. These licensure and certification requirements are a synthesis of the Medicare conditions of participation for hospitals and the Medicare conditions of participation for rural health clinics, which we just talked about. At the same time, the licensure and certification requirements lessen the regulatory burden on small facilities and assure that the facilities provide quality services.

The criteria also make provisions for the use of physician extenders, such as nurse practitioners and physicians' assistants just as rural health clinics do now. An MAF can be staffed with a combination of physicians and allied health officials or under some conditions with a physician extender operating under established protocols and under the periodic supervision of a physician.

These are not hospitals. The four day upper limit and length of stay means that they will treat only low intensity served short-term acute care patients. By necessity, this means they will treat a narrow range of patients. Because the scope of services is reduced, the regulations governing care also can be reduced.

Now, these medical assistance facilities are not the answer even in Montana for all of the problems of rural hospitals. In most of the areas in which we've got rural hospitals located now, I believe we need to maintain rural hospitals. But this experiment that is going to be applied to six or seven hospitals in Montana will deal with the problem of communities that can no longer maintain a hospital under any set of circumstances and can no longer maintain community practices independently but might be able to maintain one kind of a health care provider entity that would meet the needs of those communities. It is a solution that we have advocated to the Health Care Financing Administration which has provided a grant to help them establish the rules and regulations under which they will operate, and we have also advocated the Health Care Financing Administration, when that is done successfully, to go ahead and provide waivers under normal rules of reimbursement so that those facilities will be able to operate and we will be able to find out if they are one way that we can solve the problem. At any rate, it is a homegrown solution out of Montana and the kind of solution I think we need to look for.

I have recently been in Texas where there is a state legislative commission that is looking at rural hospitals and in Michigan where the governor has established a similar kind of task force to look at the problems of access to care in rural communities. And these task forces are looking at how Medicaid regulations might be changed and Medicaid services might be changed within the state to provide maximum support for the continuation of rural hospitals within those states as one of their agendas, their larger agenda in each case being the maintenance of access of reasonable cost.

I mentioned, Senator, the program that the Senate has recently passed for hospital transition grants. I should tell you that New York already had such a program and continues to operate such a program on a lower level of funding.

We have heard about the problem of the rise in the number of people who cannot pay for themselves, and we have heard about that from the perspective of the hospitals and the tremendous burden it places on them. And I think that that is a very valid point because many times this debate is construed in such a way that the hospital should be providing the care for all the people who cannot afford to pay.

But to the extent to which we follow that prescription and we have a large number of people who cannot afford to pay, it is a prescription for disaster for the hospital itself because the hospital alone and the individual doctor working in a poor area, in many cases, cannot provide the level of uncompensated services to the people that is necessary and still maintain their practices in those areas. They will have to leave under those circumstances in some cases, and some states are recognizing this and are trying to provide ways to protect either the hospital and/or the medical practices in that state.

In New York, for example, there is an all payers system in which all patients of hospitals in a given year help to pay for the care of those patients who cannot afford to pay. Or in Florida there is a statewide uninsured pool, not unlike some uninsured motorists pools, that provides assistance for patients who cannot afford to pay and also provides assistance to the hospitals who take care of them. In Pennsylvania, such a system is under consideration, and, as was mentioned earlier, in Missouri such a system is under consideration.

These indigent care solutions that are being developed in a statewide basis involve four sources of support in general: General revenue taxes; dedicated taxes is the second kind, which includes what are often called sin taxes, such as cigarette and alcohol; sales taxes and excise taxes. There are discretions of using the lottery in some states for financing indigent care and finally, there are surcharges and providers and insurances so that—In Florida, hospitals pay a surcharge for those patients who are admitted under this program, but they benefit to a much greater extent according to the extent of the medically needed population that they provide. So we have states in the hospital arena providing at this point a great many creative ideas in trying to solve these problems.

If we look at the issue of trying to get health professionals into rural areas, in North Dakota the medical school has an admissions policy that is based on two hundred points. One hundred points is your overall record as a student and one hundred points is your record of residence in North Dakota because their idea is that only a North Dakotan is really going to be enthusiastic about practicing medicine for a whole career in North Dakota.

Senator COCHRAN. And they're right.

Mr. HUMAN. But that's not a bad solution for other states, as well. Mississippi, as it was indicated, has a high percentage of its medical school graduates who stay within the state, but I think that the issue of states monitoring medical schools to make sure that they are producing graduates who go on into family medicine and into general pediatrics and into general internal medicine, the specialties we need most in rural areas, legislatures need to monitor that very carefully.

They need to provide the incentives to medical schools to do more of that and, as has been suggested, to provide community practice opportunities for physicians in their residency programs and in their undergraduate experience, as well, because those lead to more doctors who understand and want to practice in communities and in rural areas.

If we look at South Carolina, they have a scholarship program much like the National Health Service Corps Program that provides doctors to under-served areas who graduate from the University of South Carolina Medical School having been supported by the state. Or if we look to South Dakota, there is the state and community partnership to do the same thing so that a medical student is identified or a university student identified, who then goes on to medical school and returns to the community to practice from which he came. And in return, his medical school education or her medical school education is paid for part by the state and part by the community, which sponsored the student in the first place.

Or if we look to North Carolina, the state supports rural health centers much like the community health centers programs that have augmented and expanded what can be done in that state. So states are getting involved, too.

Finally, I'd like to talk just a little bit about communities. Fifty-two percent of our rural hospitals have local tax support. These are the hospitals that are likely to survive. These are the hospitals in which communities have shown that they have a stake in those hospitals.

Or let's take a look at the issue of selling your hospital within your community. I think we need to do more of that. I think we need to market our hospitals, our rural community hospitals, to the communities in which they are located. We need to make rural folks understand that they will lose those hospitals unless they support them. And I believe that hospitals have to do this, and I believe that mayors have to do this; and I believe that community leaders have to do this, and they have to show that they mean business by going to these hospitals themselves because in too many communities only the older folks, the parents and the grandparents are going to the community rural hospitals and the younger people are going out of the community into the larger urban hospitals. They will regret that decision when they get older themselves and don't feel that they have that option and they no longer have a hospital. So I'd like to see a lot more done.

We've also had mentioned the idea of hospitals cooperating with non-predatory, tertiary hospitals so that the tertiary hospitals get the patients with open heart surgery, and we in our rural hospitals get technical assistance. We get our patients back. We get outreach surgery. We get consultations and so forth.

We also need to look to the Johnson models and other cooperatives of hospitals. In Wisconsin they really do have a 15-member hospital group that was formed on the basis of a cooperative, and they've gone beyond purchasing. They're all small rural hospitals, some now specialize and provide obstetrics and some don't provide obstetrics anymore, and that's by arrangement. They also, in addition to specializing, now apply for grants from the foundations and from the federal government and from the states as an overall entity, and they have found that they are much more successful than they were when they were fifteen individual hospitals, five of whom were expected to close and none of whom have closed in the last five years of association.

Finally, having talked about the federal government and states and communities, I want to mention just a word about our Office of Rural Health, particularly because it's appropriate to do so in Mississippi. We have worked very hard in a number of initiatives, including a National Advisory Committee on Rural Health, which our secretary has recently appointed and which we staff.

That committee is headed by former governor Robert Ray of Iowa, and they have established as their first priority to try to deal with in their January meeting equity and Medicare reimbursement to rural hospitals. And that January meeting, they have decided, will not be in Washington, but will be in Jackson, Mississippi. And we're beginning to make the arrangements.

Senator COCHRAN. All right.

Mr. HUMAN. We have a Mississippi member on that committee, Dr. Shirley Jones, who is the Dean of Social Work at the University of Southern Mississippi, and she was recommended by Senator Cochran. So since Dr. Jones is not here to thank you, you may thank Senator Cochran because she's the one who, when the committee started talking about Hilton Head and other places said, "No, I think we need to go some place where there are some problems and where there are some creative people around who are working to solve these problems and to make some recommendations to us, and I suggest that we go to Mississippi." And that is what they did.

I've probably extended my time and gotten more wound up than I should, but I will say that I know that there's been a sense of discouragement on the part of some folks. And if I were in a rural hospital that was in danger of closing, I would be discouraged, too. But as we do look at what has happened, we see not only the problems but that we are beginning to make progress in solving them. And I do believe that if rural constituencies keep up the pressure in their communities and their states and with us in the federal government and persevere over the next several years, that there is a great deal of interest in rural health throughout the country at this point and in the problems of the aged and that it is possible that we will make an awful lot more progress. I think that that is essential because I think that two principles are involved here that ought to be important to all of us.

The first is equity and the second is decentralization. By equity, I mean that if you pay your taxes and you go to the IRS and you tell them that you live in a rural area, they aren't going to give you a discount. And similarly, it seems to me that when we look for our basic services from Washington or from Jackson or from another state capital, we have a right to expect that that principle of equity will also be followed. We have a right to expect, not a burn unit in every little rural hospital or every rural town, but that we have and expect that there will be a very strong emphasis in equity for us and our needs, as well.

Secondly, I think we need to look to the principle of decentralization. I don't think we want to be the kind of a country in which to get a good education or good health care you have to leave your community and go to some large city in order to get that or any other kind of service. I don't think we want to be the kind of a country in which rural communities are not viable.

I think we want to see our population spread across the whole continent in communities that are viable if they're small as well as communities that are viable if they are large. And it is those two principles that I think that rural constituencies need to continue to advocate everywhere, and I think that we will make progress if we do that.

Senator COCHRAN. Let me applaud you and thank you for being here today to help us with our hearing and help us better understand what some of the attitudes are in our department in Washington. I thank you for being here and want to encourage you to continue your strong advocacy with the Health Care Financing Administration to urge equity in reimbursements, Medicare reimbursements for hospitals and physicians.

I think that if we can accomplish one thing as a result of this hearing and that is to bring home to those who have won this argument in the past that that decision needs to be changed, that decision needs to be reversed—and we need to improvise Medicare reimbursements—We will have made a major step forward in saving a lot of our health care systems in rural America.

Now, I agree with you that it is so important for us to keep rural America, our small towns and communities, as an option for places to live and work and enjoy our lives. It would really be a tragedy indeed if we saw only larger cities surviving as we reach the end of this century. That would really be unfortunate, in my opinion, and we've got to work to make sure that doesn't happen.

Well, with training assistance grants from Washington with some of your assistance and with bringing the message of this hearing back to Washington with you to your colleagues and with our efforts in the Senate to be sure that future legislative actions take into account the concerns that we've heard expressed today, I think we will have certainly made a contribution that's important to our state and the many others as well.

Mr. HUMAN. Senator, if I could add just one thing about the Health Care Financing Administration. Their director, Dr. Bill Roper, is, of course, a physician from Alabama, and he has been a person who has been increasingly interested in rural health care.

And when I go back, we will be briefing him and his staff on this hearing.

We have been working with them in the implementation of the Health Care Transition Bill to try to get as much of the funds that the Congress has appropriated as quickly out to rural hospitals as we can. He did come before our National Advisory Committee on Rural Health, and recently, he has visited rural hospitals in a number of states.

He and his staff are increasingly involved and interested in trying to solve these problems, and we are certainly working as a primary emphasis with them on a day by day basis. He has gone so far as to detail to us some of our staff persons, our professional staff people, so that we can be sure that they are getting the message throughout that Administration on a regular basis. So I do feel over the past year a lot of progress has been made.

They are also considering with us departmental legislative proposals which we have not been able to clear as yet, but which we hope we will be able to clear, which would provide relief, particularly for sole community hospitals which have been the hardest hit hospitals.

Senator COCHRAN. Thank you very much for that. Let me say that we will be adding material to the record of this hearing. I have requested at least one additional piece of information dealing with IRS regulations so that we can have a complete record. If anyone else would like to submit testimony in the form of a letter or written comments, I would be happy to receive those and include them in the record as a part of the transcript of this hearing so that we will have a complete picture of the impressions and attitudes and views of Mississippi citizens and health care professionals, state and local officials who may be interested in work of our Subcommittee.

[Additional material submitted for the record follows:]

TESTIMONY OF JOSEPH H. POWELL, PRESIDENT
BAPTIST MEMORIAL HEALTH CARE SYSTEM, INC.
FIELD HEARING ON RURAL HEALTH SERVICES
BEFORE SENATE SUBCOMMITTEE ON AGING
OCTOBER 20, 1988
TUPELO, MISSISSIPPI

October 18, 1988

Honorable Spark M. Matsunaga
Chairman, Subcommittee on Aging
Committee on Labor & Human Resources
United States Senate
Hart Building, Room 404
Washington, DC 20510

Testimony of Joseph H. Powell, President
Baptist Memorial Health Care System, Inc.
Field Hearing on Rural Health Services
Before Senate Subcommittee on Aging
October 20, 1988
Tupelo, Mississippi

Baptist Memorial Health Care System, Inc. would like to thank the Chairman and members of the Senate Subcommittee on Aging for recognizing the critical condition of health care in rural communities and for soliciting local input on public and private initiatives which may be formed to address the many problems facing the delivery of health services in rural communities.

This testimony is presented by Health Care Development Corporation of the Baptist Memorial Health Care System, 899 Madison Avenue, Memphis, Tennessee 38146 in its interest of the improvement of medical services in rural communities. The Health Care Development Corporation owns and operates Baptist Memorial Hospital-Booneville, Baptist Memorial Hospital-DeSoto; it has management contracts for Tippah County Hospital in Ripley, Mississippi and Union County Hospital in New Albany, Mississippi. Additionally, the Corporation provides affiliate services to Oxford/Lafayette Medical Center in Oxford, Mississippi, Greenwood Leflore Hospital in Greenwood, Mississippi, Webster County General Hospital in Eupora, Mississippi, Oktibbeha County Hospital in Starkville, Mississippi, Magnolia Hospital in Corinth, Mississippi, and Marshall County Hospital in Holly Springs, Mississippi. Also, the Health Care Development Corporation is extensively involved in providing health/medical services in rural areas of North Mississippi.

The Corporation has hospitals in the Tennessee communities of Union City, Huntingdon, Ripley, and Covington, and in the Arkansas communities of Forrest City and Hardy. These ownership and affiliation relationships are indicative of a comprehensive interest in the delivery of health care in rural areas.

It is generally agreed that the most vulnerable hospital today in the current health care environment is the small, rural hospital. This question deserves much discussion before this important component is permitted to go out of existence, for all citizens of our country deserve to have accessible health services on a reasonable basis. If a given rural hospital does not prove viable, there must be some alternative for medical services.

Those services need not meet the scope of services available today in the urban hospital. Yet there is a challenge to meet a basic level of medical services within each rural community. This calls for the presence of family practioner physicians within each rural community and internal medicine specialists depending upon the size and, needs of the rural community. It also calls for supporting ancillary medical services.

The best organization for the assurance of appropriate medical services is a hospital. In the case of the rural hospital, it must be dedicated to its respective community. The implication of its responsibility is that the hospital must not focus entirely on acute inpatient cases. First of all, it must be active in contracting the needed physicians to practice in the community as well as to provide hospital services when the physicians need to hospitalize their patients. Basic physician services should be available without the requirement of excessive travel by patients who live in rural communities.

Further, a rural hospital should work closely with its community in determining the health services that it can and would provide. Inpatient care is only one of these. An emphasis would be placed on outpatient care as well. Also, a variety of other services would be considered such as skilled nursing care and nursing home care, home health programs, durable medical equipment services, alcohol and drug abuse services, psychiatric services, outpatient rehabilitation services, and particularly emergency medical services. The scope of these services would have to be decided in each rural community and in relationship to the facilities of nearby communities providing some of these services when it is not feasible for the local community to do so. The approach would be a planning approach in light of the resources available or potentially available within the given community and the linkages that might be formed with other facilities and agencies in nearby communities. A very important dimension of these considerations is the integration of the rural hospital into a multi-hospital system with significant resources and to which patients with more complicated illnesses could be referred. It would be recognized that it is not possible for all rural communities to have a hospital. If a hospital is not feasible in a given situation, the community would then focus on ambulatory services. A center for this purpose would be highly desirable. This organization must have the necessary linkages to other providers.

From the above points, it seems logical to ask the federal government to provide additional assistance in two ways:

1. A means of encouraging physicians to locate in rural communities.
2. Support the reshaping of the rural hospital so that it better serves its community, either with a more appropriate range of services or with linkages (arrangements) with other health care facilities and agencies.
3. If a hospital is not feasible, support should be given to a community health center with family practice physicians.

Perhaps, the above recommendations are closely interrelated. If there is an adequate infrastructure within the community, a physician would be more likely to locate in that community and practice. Hence, a particularly new program by the federal government would be grants to rural hospitals to reshape their service programs more directly to community needs. The grants would cover certain costs to revise facilities, to do community planning, and have more funds for the start-up of new services. It might be well to request that states match the federal funds to some degree.

The approval of such grants would be based on:

1. Evidence of effectively serving the rural community.
2. Evidence of support by the community and the medical profession.
3. Reasonable probability of success of the reshaping.
4. Adequate linkages to provide medical services not considered feasible within the community.
5. Reliable methods of referring patients for sophisticated medical services.
6. Rational planning underlying the reshaping.

An alternative to a hospital is a community health center with family practice physicians and appropriate outpatient services. Grants would be valuable to rural communities to accomplish such centers. This would be a partnership of the federal government and states.

This testimony urges that whatever the federal government does in the way of attempting to improve the health care delivery system in rural areas that it give as many incentives as possible to encourage private initiative to deal with the problems in rural health care delivery. Undue legal restrictions would be removed to permit and encourage the use of physician assistants and nurse practitioners as extenders of physicians. Too, great flexibility from a legal standpoint should be made possible in order for use of hospital facilities. This is especially important in shifting the use of the hospital facility from one type of care to another. Further, the non-profit hospital should be free to enter into innovative arrangements in attracting physicians that would not be considered as jeopardizing its tax-exempt status. Low interest loans to private organizations would also be considered in reshaping the rural hospital or in developing a rural health center.

It would be helpful to give attention to relaxing government regulations that prevent governmentally owned hospitals (many of the rural hospitals are owned and operated by counties) from entering into joint ventures, especially with physicians. Such joint ventures would make additional capital available in rural areas, would possibly facilitate some expansion of services, and could tie physicians more permanently to the rural areas. Further, since there is an increasing reluctance of obstetricians or family practice physicians to practice obstetrics in rural areas, some governmental assistance to protect against malpractice costs could prove helpful to alleviate this problem.

Further, the matter of the effectiveness of the NATIONAL HEALTH SERVICE CORPS is assuring physicians for rural communities must be evaluated. In the view of the Health Care Development Corporation of Memphis, Tennessee, this program has not been very successful. Consequently, we recommend that some other program for encouraging physicians to practice in rural areas be provided. For example, certain support and incentives could be given by the federal government to family practice medical groups or to multi-specialty physician groups located in urban centers to provide the physician services in the community under contract with the rural hospitals. Some initial financial support would be necessary, but it is felt that this approach would prove more beneficial than the experience with the NATIONAL HEALTH SERVICE CORPS.

A major problem affecting all hospitals is the growing amounts of uncompensated hospital care. As this demand has increased, the means of providing it within the hospital has dwindled due to retrenched Medicare payments and more reluctance by business and employers to pay any more than the actual cost of the services that they purchase. Hence, in the view of hospitals, the burden of providing medical services to the uninsured and medically indigent has become a societal problem and must be solved by society. The Medicaid program has failed miserably in its promise and now requires strengthening by the federal government and states. Eligibility standards with reference to the definition of poverty must be raised to realistic levels, and this means some more funding of the Medicaid program would occur.

Also, national health care data show that there are 37,000,000 uninsured people in our nation today, and many of these people are employed at low wages and have no health insurance. Some reasonable approach to this problem must be undertaken, such as the formation of insurance pools, and a sharing of responsibility for the financing of health insurance for these people to be undertaken by the employer, state, and federal government.

The removal of barriers to health services through the improvement of the Medicaid program and the providing of health insurance for the working poor will improve the financial soundness of rural hospitals and other hospitals as well.

A major problem facing all the hospitals of America is that of the acute shortage of professional nurses and the seemingly impending shortage of classes of allied health personnel: radiological technologists, laboratory technologists, and technicians, physical therapists, occupational therapists, pharmacists, respiratory therapists, and possibly others.

Of all the problems besetting the hospitals located in rural areas that are operated by Baptist Memorial Health Care System, Inc., this problem is foremost. Its dimension is such that it affects seriously the quality of care that a hospital can provide. It is with respect to this issue that we direct our strongest testimony.

There is abundant evidence of this shortage in the experience of hospitals. Again the impact is felt most strongly in the rural hospital. An underlying problem is the fact that the demographic trends that we are experiencing in the American society are reducing the number of young people who are available for the work force. In succinct terms, the baby boom has now become the baby bust. In the 1970s, as a result of the so-called baby boom, the labor force in our country grew at an unprecedented 2.5 percent per year. Between 1985 and 1990, the labor force grew only at 1.2 percent annually. In the 1990s the annual rate will decrease (it is predicted) to 0.8 percent per year. This phenomenon adds up to the fact that in a few years there will be aggressive competition for first-rate

In conclusion, we want to emphasize that as we strengthen medical services in rural communities, whether by reshaping the local hospital or by initiating a community health center, and also by assuring the availability of physician and other health care professionals, we are advancing the quality of life for many elderly citizens who live in our rural communities. As we all know, rural communities typically have a population that is characterized by a high proportion of aged people.

Baptist Memorial Health Care System, Inc., would again like to thank the Subcommittee for recognizing the health needs of our elderly citizens who reside in rural communities. We hope our comments and suggestions on improving rural health services are of assistance to the Subcommittee as it formulates public policy in this important area.

Testimony prepared by the Health Care Development
Corporation of Baptist Memorial Health Care System, Inc.,
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October 20, 1988

employees. This situation is superimposed on a growing demand for health care professionals, particularly professional nurses and certain allied health professionals.

There is excellent documentation of the nurse shortages. The data of the American Hospital Association shows a 11.3 percent nurse shortage in American hospitals. The percentage is significant enough to affect the quality of care in our hospital. The recent report of the Secretary's Commission on Nursing (July, 1988) reports that "the shortage of registered nurses is real, is widespread, and is of significant magnitude." If further reports the following relevant points:

1. RN vacancies have tripled between 1983 and 1987.
2. Enrollment in nurse programs also has declined.
3. The current shortage exists despite the fact that the actual number of nurses has continued to increase.
4. Presently, there are 91 registered nurses per 100 hospital patients, up from 50 nurses per 100 patients a few years ago.
5. Recruitment time for a new nurse requires a time period of in excess of 90 days.
6. There is an increase in the severity of the illness of patients due to AIDS, aging of the population, and technological advances.
7. Nursing homes are requiring more nurses.
8. Hospitals have been employing fewer practical nurses and aides.
9. There has been a growth in alternative care providers.
10. There are serious problems in retention of nurses due to salaries not being adequate and due to working conditions for nurses.
11. Nursing suffers from a poor image with the public.
12. The participation rate of registered nurses is high and the unemployment rate is down to 0.7 percent.

According to a present study by the Institute of Medicine, the shortage of professional nurses in only one shortage. There are serious projected shortages for physical therapists, occupational therapists, medical records personnel, radiological technologists, clinical laboratory workers, and dental hygienists. The situation is especially difficult for hospitals as many health professionals turn to health maintenance organizations and freestanding health facilities where pay is higher, the work is less stressful and the hours more convenient.

According to the August 26, 1988 issue of the Journal of the American Medical Association a significant reduction in the schools that train allied health professionals is occurring. This is taking place principally in hospitals due to the lack of funds available for such educational programs.

It is recognized that the federal government has been involved in providing funds for nursing education in the past but this provision has been downward until the present time. The federal government, to the awareness of this witness, however, has not been involved in the providing of funds for the education of allied health groups, particularly for those groups which now show that shortages are emerging. These groups are so very crucial to the operation of hospitals and other health care facilities. The crucial aspect here applies particularly to the aged population.

Consequently, we recommend that the federal government undertakes the following:

1. Continue its present program of funding nursing education but at higher levels than in the past and work with states through legislative means to give states more support to strengthen their educational activities for the training of nurses.
2. Provide grants that would be used by hospitals, hospital associations, or other institutions (e.g., colleges or universities offering nursing education) to develop practice models for the recruitment and retention of nurses in the nursing profession.
3. Initiate grants by the federal government to states for strengthening various allied health education programs offered by state educational institutions. Also, the grant funds would be available to private institutions as well.

Senator **Cochran**. Again, I want to express my appreciation to Senator Matsunaga for authorizing this hearing, to staff members who have helped us make arrangements for the hearing and conduct it, to Elma Henderson who's here. Stand up, Elma, and we thank you so much for all of your fine work and Senator Matsunaga's staff; and Stacy Smith, our court reporter from Batesville, Mississippi; and my own staff members who have been so helpful in making arrangements and being here to help in the conduct of this hiring—Linda Hudson, who has been here at the table with me today and Anne Cherry, who is here from Meridian; Janice Mitchell, who is from Jackson and has gone back to our office in Jackson but was here for most of the hearing today; and Wiley Carter, who is my administrative assistant and has been here today, as well.

I want to thank all of them for the excellent work they've done and again to our host, North Mississippi Medical Center here in Tupelo, my deepest appreciation for the hospitality and especially to Janet Meeks, who has been put in charge of our arrangements today. She's done a wonderful job helping us prepare for the hearing and making sure everything went well. We appreciate that. And to all of you who have been here, witnesses and spectators and others, thank you very much for making this a very successful hearing. We are now adjourned.

[Whereupon, at 3:15 p.m., the subcommittee adjourned subject to the call of the Chair.]

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